Summary Plan Description

United HealthCare High Deductible PPO Plan

for

the State Health Benefit Plan

Group Number: 702030
Effective Date: January 1, 2006

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Introduction

This booklet is your Summary Plan Description (SPD) and describes the provisions of your State Health Benefit Plan (SHBP), which is also referred to in this booklet as the "Plan." Use this SPD as a reference tool to help you understand the Plan and maximize your coverage.

The SHBP is governed by the regulations of the Department of Community Health (DCH) Board, Chapter 111-4-1 Health Benefit Plan. If there are discrepancies between the information in this SPD and DCH Board regulations or the laws of the state of Georgia, those regulations and laws will govern at all times.

This booklet is notice to all members of the SHBP's eligibility requirements and benefits payable for services provided on or after January 1, 2006, unless otherwise noted. Any and all statements to Members or to Providers about eligibility, payment or levels of payment that were made before January 1, 2006 are canceled if they conflict in any way with the provisions described in this booklet.

The SHBP reserves the right to act as sole interpreter of all the terms and conditions of the Plan, including this booklet and the separate medical policy guidelines that serve as supplement to this booklet to more fully define eligible charges.

The SHBP also reserves the right to modify its benefits, level of benefit coverage and eligibility/participation requirements at any time, subject only to reasonable notification to Participants. When such a change is made, it will apply as of the modification's effective date to any and all charges incurred by Members on that day and after, unless otherwise specified by the DCH.

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How to Use this Document

We encourage you to read your SPD and any attached Riders and/or Amendments carefully.

We especially encourage you to review the Benefit limitations of this SPD by reading (Section 1: What's Covered--Benefits) and (Section 2: What's Not Covered--Exclusions). You should also carefully read (Section 10: General Legal Provisions) to better understand how this SPD and your Benefits work. You should call United HealthCare if you have questions about the limits of the coverage available to you.

Many of the sections of the SPD are related to other sections of the document. You may not have all of the information you need by reading just one section. We also encourage you to keep your SPD and any attachments in a safe place for your future reference.

Please be aware that your Physician does not have a copy of your SPD and is not responsible for knowing or communicating your Benefits.

Information about Defined Terms

Because this SPD is a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in (Section 11: Glossary of Defined Terms). You can refer to Section 11 as you read this document to have a clearer understanding of your SPD.

When we use the words "we", "us", and "our" in this document, we are referring to SHBP. When we use the words "you" and "your" we are referring to people who are Covered Persons as the term is defined in (Section 11: Glossary of Defined Terms).

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Your Contribution to the Benefit Costs

The Plan may require the Participant to contribute to the cost of coverage. Contact your benefits representative for information about any part of this cost you may be responsible for paying.

Customer Service and Claims Submittal

Please make note of the following information that contains United Healthcare department names and telephone numbers.

Customer Service Representative (questions regarding Coverage or procedures): 1-877-246-4195

Monday – Friday 8:00 a.m. – 8:00 p.m.

Prior Notification: 1-877-246-4195

For detailed explanation on Prior Notification please see page 6.

Mental Health/Substance Abuse Services:

1-877-246-4195

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Plan's Eligibility Unit: 404-656-6322, Atlanta

800-610-1863, toll-free outside Atlanta

Monday-Friday, 8:30 a.m. to 4:30 p.m.

Membership Correspondence for non-claim/eligibility issues:

State Health Benefit Plan

Membership Correspondence Unit

P.O. Box 38342, Atlanta, GA 30334

Note: SHBP handles all eligibility appeals. All Member correspondences sent to the Plan (including SHBP forms and Medicare Part D ID card copies) should include the Participant's Social Security Number (SSN). Including your SSN will help prevent delay in processing your requests.

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Claims Submittal Address:

United HealthCare Insurance Company

Attn: Claims

PO Box 740806

Atlanta, Georgia 30374-0800

Requests for Review of Denied Claims/Appeals and Notice of Complaints:

Name and Address For Submitting Requests:

United HealthCare Insurance Company

PO Box 30994

Salt Lake City, Utah 84130-0432

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Section 1: What's Covered—Benefits

The purpose of the State Health Benefit Plan is to pay most of the costs of the medically necessary care and treatment of illness and accidental injury for covered Plan Members.

This section provides you with information about:

- Accessing Benefits.
- Coinsurance and Eligible Expenses.
- Annual Deductible, Out-of-Pocket Maximum and Maximum Plan Benefit.
- Covered Health Services. We pay Benefits for the Covered Health Services described in this section unless they are listed as not covered in (Section 2: What's Not Covered--Exclusions).
- Covered Health Services that require you notify United HealthCare is your responsibility. You are required to obtain the necessary prior notification or prior approval for all inpatient admissions and certain covered services under the Plan. You should contact member Services regarding notification requirements and verification of covered services.

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Accessing Benefits

You can choose to receive either Network Benefits or Non-Network Benefits. To obtain Network Benefits you must see a Network Physician or other Contracted provider. The Plan reimburses up to the Plan's allowed amounts. Note: Non-Covered Health Services are not eligible for reimbursement, regardless if the provider is Network or Non-Network.

You must show your identification card (ID card) every time you request health care services. If you do not show your ID card, providers have no way of knowing that you are enrolled under the Plan.

Benefits are available only if all of the following are true:

- Covered Health Services are received while the Plan is in effect.
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in (Section 9: Continuation of Coverage under COBRA) occurs.
- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements specified in the Plan.

Depending on the geographic area and the service you receive, you may have access through United HealthCare's Shared Savings Program to non-Contracted providers who have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from these providers, and if your Coinsurance is expressed as a percentage of Eligible Expenses for Non-Network Benefits, that percentage will remain the same as it is when you receive Covered Health Services from non-Contracted providers

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who have not agreed to discount their charges; however, the total that you owe may be less when you receive Covered Health Services from Shared Savings Program providers than from other non-Contracted providers, because the Eligible Expenses may be a lesser amount.

Coinsurance

Coinsurance is the amount you pay each time you receive certain Covered Health Services. For a complete definition of Coinsurance, see (Section 11: Glossary of Defined Terms). Coinsurance amounts are listed on the following pages next to the description for each Covered Health Service. Please note that when Coinsurance is calculated as a percentage (rather than as a set dollar amount) the percentage is based on Eligible Expenses.

Eligible Expenses

Eligible Expenses for Covered Health Services, incurred while the Plan is in effect, are determined by SHBP or by United Healthcare. In almost all cases our designee is United HealthCare. For a complete definition of Eligible Expenses that describes how payment is determined, see (Section 11: Glossary of Defined Terms).

We have delegated to United HealthCare the discretion and authority to determine on our behalf whether a treatment or supply is a Covered Health Service and how the Eligible Expense will be determined and otherwise covered under the Plan.

For Network Benefits, you are not responsible for any difference between the Eligible Expenses and the amount the provider bills. For Non-Network Benefits, you are responsible for paying, directly to the non-Contracted provider, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses. The SHBP does not have the legal authority to intervene

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when non-Contracted providers balance bill you. As a result, the SHBP cannot reduce or eliminate amounts balance billed. The SHBP cannot make additional payments above the allowed amounts when you are balance billed by non-Contracted providers.

Notification Requirements

Prior notification is required before you receive certain Covered Health Services. You are responsible for notifying United HealthCare before you receive these Covered Health Services. Services for which you must provide prior notification appear in this section under the *Notify United HealthCare?* column in the table labeled *Benefit Information*.

To notify United HealthCare, call the telephone number on your ID card.

We urge you to confirm with United HealthCare that the services you plan to receive are Covered Health Services, even if not indicated in the *Notify United HealthCare?* column. That's because in some instances, certain procedures may not meet the definition of a Covered Health Service and therefore are excluded. In other instances, the same procedure may meet the definition of Covered
Health Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions such as:

- The Cosmetic Procedures exclusion. Examples of procedures that may or may not be considered Cosmetic include: breast reduction and reconstruction (except for after cancer surgery when it is always considered a Covered Health Service.
- The Experimental, Investigational or Unproven Services exclusion.

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- Any other limitation or exclusion of the Plan.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before we pay Benefits under the Plan), the notification requirements described in this SPD do not apply to you. Since Medicare is the primary payer, we will pay for covered Health services as secondary payer as described in (Section 8: Coordination of Benefits). You are not required to notify United HealthCare before receiving Covered Health Services.

Prior approval is required for transplant services and home intravenous medication therapy, even if Medicare is primary, and for expenses that Medicare does not cover. You should call United Behavioral Health whenever you need mental health and substance abuse care, even if you have primary coverage through Medicare or a health plan other than SHBP.

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Payment Information

Payment Term	Description	Amounts
Annual Deductible	The amount you pay for Covered Health Services before you are eligible to receive Benefits. For a complete definition of Annual Deductible, see (Section 11: Glossary of Defined Terms). The actual amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. For a complete definition of Eligible Expenses, see (Section 11: Glossary of Defined Terms).	***Network*** $1,100 per Covered Person per calendar year, not to exceed $2,200 for all Covered Persons in a family. ***Non-Network*** $2,200 per Covered Person per calendar year, not to exceed $4,400 for all Covered Persons in a family.
Out-of-Pocket Maximum	The maximum you pay for Covered Health Services, out of your pocket, in a calendar year for Coinsurance. For a complete definition of Out-of-Pocket Maximum, see (Section 11: Glossary of Defined Terms).	***Network*** $1,700 per Covered Person per calendar year, not to exceed $2,900 for all Covered Persons in a family. The Out-of-Pocket Maximum does include the Annual Deductible. ***Non-Network*** $3,800 per Covered Person per calendar year, not to exceed $7,000 for all Covered Persons in a family. The Out-of-Pocket Maximum does include the Annual Deductible.

Payment Term	Description	Amounts
Maximum Plan Benefit	The maximum amount we will pay for Covered Health Services during the entire period of time you are enrolled under The State Health Benefit Plan (SHBP). For a complete definition of Maximum Plan Benefit, see (Section 11: Glossary of Defined Terms).	***Network and Non-Network*** $2,000,000 per Covered Person (combined for all SHBP options)

Prior Notification is required before you receive certain Covered Health Services.

You are responsible for notifying Care Coordination before you receive the following Covered Health Services:

- Dental Services - Accident Only
- Home Health Care
- Hospice Care
- Reconstructive Procedures
- Admissions to a Skilled Nursing Facility/ Inpatient Rehabilitation Facility
- Hospital-Inpatient Stay

For an Inpatient Stay of a mother and/or the newborn that will be more than the time frames described of:

- 48 hours for the mother and newborn child following a normal vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

- As soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center).

Please refer to the Mental Health and Substance Abuse section for notification requirements pertaining to Mental Health and Substance Abuse treatment.

****NON NOTIFICATION PENALTY IS 50% OF ELIGIBLE EXPENSES**

Benefit Information

Description of Covered Health Service	Notification Required?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
1. Ambulance Services - Emergency only Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be performed. Non-emergency transportation of patient or family member to or from a medical facility, Physician's office, or patient's home is excluded, unless pre-approved by Care Coordination in lieu of an acute-care Hospital stay. **NOTE**: Emergency, life threatening, medically necessary ambulance transportation is available to the CLOSEST facility able to treat the condition, even if you are out of the country. If you are traveling outside the U.S. and wish to be transported back into the U.S. for treatment, you may want to consider purchasing travel insurance. If the destination is not the closest facility able to treat the condition, the SHBP will not assume financial responsibility for the additional transportation charges.	***Network*** No ***Non-Network*** No	*Ground Transportation:* 10% *Air Transportation:* 10% 40%	Yes Yes	Yes Yes

Description of Covered Health Service	Notification Required?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
2. Dental Services: **A. Accident only** Dental services when all of the following are true: • Treatment is necessary because of accidental damage. • Dental services are received from a Doctor of Dental Surgery, "D.D.S." or Doctor of Medical Dentistry, "D.M.D.". • The dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident. Benefits are available only for treatment of a sound, natural tooth. The Physician or dentist must certify that the injured tooth was: • A virgin or unrestored tooth, or • A tooth that has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant and functions normally in chewing and speech.	***Network*** Yes ***Non-Network*** Yes	10% 40%	Yes Yes	Yes Yes

(Benefit information continued on next page)

Description of Covered Health Service	Notification Required?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Dental services for final treatment to repair the damage must be both of the following: • Started within three months of the accident. • Completed within 12 months of the accident. Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered an "accident". Benefits are not available for repairs to teeth that are injured as a result of such activities.				
B. Oral Care The Plan has limited dental and oral care benefits. Prior Approval may be required - **contact Care Coordination**. The Plan will consider coverage only for: • Prompt Repair of natural teeth or tissue in connection with reconstructive surgical procedures following treatment of oral cancer, • Surgery to treat lesions of the mouth, lip or tongue, if the lesion requires a pathological examination,	***Network*** Yes	10%	Yes	Yes
	Non-Network Yes	40%	Yes	Yes

(Benefit information continued on next page)

Description of Covered Health Service	Notification Required?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?

- Surgery (frenulectomy) for treatment of a child's speech impairment, when medically indicated,
- Surgery of accessory sinuses, salivary glands or ducts, - surgery to repair cleft palates,
- Orthognathic surgery to correct obstructive sleep apnea and for dependents age 19 and under born with specific craniofacial syndromes, and
- Institutional and anesthesia charges associated with a non-covered dental care normally performed in a dental office, but due to the patient's medical condition, care in a Hospital setting is warranted, as required under State Law.

Repairs that are not performed promptly (as defined) will be denied unless a compelling medical reason exists. X-Rays and other documentation may be required to determine benefit coverage.

(Benefit information continued on next page)

Description of Covered Health Service	Notification Required?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
C. Temporomandibular Joint Dysfunction (TMJ) Covered Health Services for diagnostic and surgical treatment of conditions affecting the temporomandibular joint when provided by or under the direction of a Physician. Benefits include necessary diagnostic or surgical treatment required as a result of accident, trauma, congenital defect, developmental defect, or pathology. Benefits are not available for charges or services that are dental in nature. Diagnostic testing or non-surgical therapy for TMJ dysfunction, subject to a lifetime benefit limit of $1,100 (x-rays not subject to maximum limit). **Notify United HealthCare** **Please remember that you must notify United HealthCare as soon as possible, but at least five business days before follow-up (post-Emergency) treatment begins. (You do not have to provide notification before the initial Emergency treatment.) If you don't notify United HealthCare, Benefits will be reduced by 50%; however the reduction in Benefits will not exceed Eligible Expenses for the Covered Health Services. This 50% reduction will not apply to your Out-of-Pocket Maximum**.	***Network*** Yes ***Non-Network*** Yes	10% 40%	Yes Yes	Yes Yes

Description of Covered Health Service	Notification Required?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
3. Durable Medical Equipment Durable Medical Equipment that meets each of the following criteria: • Ordered or provided by a Physician for outpatient use. • Manufactured and used for medical purposes. • Not consumable or disposable, except urinary catheters and ostomy supplies. • Not of use to a person in the absence of a disease or disability. If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the most cost-effective piece of equipment. Examples of Durable Medical Equipment include: • Equipment to assist mobility, such as a wheelchair or scooter. • A standard Hospital-type bed. • Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks). • Delivery pumps for tube feedings (including tubing and connectors). (Benefit information continued on next page)	***Network*** Yes, for items more than $1,000. ***Non-Network*** Yes, for items more than $1,000.	10% 40%	Yes Yes	Yes Yes

Description of Covered Health Service	Notification Required?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?

- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an Injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).

We and United HealthCare will decide if the equipment should be purchased or rented. For maximum benefit, you may purchase or rent Durable Medical Equipment from a United HealthCare vendor.

Notify United HealthCare
Please remember that you must notify United HealthCare before obtaining any single item of Durable Medical Equipment that costs more than $1,000 (either purchase price or cumulative rental of a single item). If you don't notify United HealthCare, you will be responsible for paying all charges and no Benefits will be paid.

Description of Covered Health Service	Notification Required?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
4. Emergency Health Services Services that are required to stabilize or initiate treatment in an Emergency and are received on an outpatient basis at a Hospital or Alternate Facility. You will find more information about Benefits for Emergency Health Services in (Section 3: Description of Network and Non-Network Benefits). **Notify United HealthCare** **To ensure prompt and accurate payment of your claim as a Network Benefit, notify United HealthCare within two business days or as soon as possible after you receive outpatient Emergency Health Services at a non-Network Hospital or Alternate Facility.** **Please remember that if you are admitted to a Hospital as a result of an Emergency, you must notify United HealthCare within one business day or the same day of admission, or as soon as reasonably possible.**	***Network*** Yes, but only for an Inpatient Stay. ***Non-Network*** Yes, but only for an Inpatient Stay.	10% Same as Network	Yes Same as Network	Yes Same as Network

(Benefit information continued on next page)

Description of Covered Health Service	Notification Required?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
If you don't notify United HealthCare, Benefits for the Hospital Inpatient Stay will be reduced by 50%; however the reduction in Benefits will not exceed Eligible Expenses for the Covered Health Service. This 50% reduction will not apply to your Out-of-Pocket Maximum.				
5. Eye Examinations • Eye examinations received from a health care provider, for diagnosis and treatment of eye condition. NOTE: We will cover eyeglasses (first pair only) after cataract surgery.	***Network*** No	10%	Yes	Yes
	Non-Network No	40%	Yes	Yes
• Benefits include one routine vision exam, including refraction, to detect vision impairment by a Contracted provider every other calendar year. Routine eye exams are not subject to the deductible. Non-network routine eye exams are not covered.	***Network*** No	10%	Yes	No
	Non-Network	Not Covered	& no benefits	for routine care
Vision Discount program available through United Health Wellness 1-888-848-9355.				

Description of Covered Health Service	Notification Required?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
6. Home Health Care				
Services received from a Home Health Agency that are both of the following: • Ordered by a Physician. • Provided by or supervised by a registered nurse in your home. Benefits are available only when the Home Health Agency services are provided on a part-time, intermittent schedule and when skilled care is required. Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true: • It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient. • It is ordered by a Physician. • It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair.	***Network*** Yes ***Non-Network*** Yes	10% 40%	Yes Yes	Yes Yes

(Benefit information continued on next page)

- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

We and United HealthCare will decide if skilled care is required by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

One visit equals up to four hours of skilled care services.

Notify United HealthCare

Please remember that you must notify United HealthCare five business days before receiving services. If you don't notify United HealthCare, Benefits will be reduced by 50%; however the reduction in Benefits will not exceed Eligible Expenses for the Covered Health Service. This 50% reduction will not apply to your Out-of-Pocket Maximum.

Description of Covered Health Service	Notification Required?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
7. Hospice Care Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social and spiritual care for the terminally ill person, and short-term grief counseling for immediate family members. Benefits are available when hospice care is received from a licensed hospice agency. Please contact United HealthCare for more information regarding guidelines for hospice care. You can contact United HealthCare at the telephone number on your ID card. **Notify United HealthCare** **Please remember that you must notify United HealthCare five business days before receiving services. If you don't notify United HealthCare, Benefits will be reduced by 50%; however the reduction in Benefits will not exceed Eligible Expenses for the Covered Health Service. This 50% reduction will not apply to your Out-of-Pocket Maximum.**	***Network*** Yes ***Non-Network*** Yes	10% 40%	Yes Yes	Yes Yes

Description of Covered Health Service	Notification Required?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
8. Hospital - Inpatient Stay Inpatient Stay in a Hospital. Benefits are available for: • Supplies and non-Physician services received during the Inpatient Stay. • Room and board in a Semi-private Room (a room with two or more beds). Benefits for Physician services are described under *Professional Fees for Surgical and Medical Services.*	***Network*** Yes	10% Wellness Newborn Care: 10%	Yes No	Yes No
Notify United HealthCare **Please remember that you must notify United HealthCare as follows:** • **For elective admissions: five business days before admission.** • **For non-elective admissions: within one business day or the same day of admission.** • **For Emergency admissions: within one business day or the same day of admission, or as soon as is reasonably possible.**	***Non-Network*** Yes	40% Wellness Newborn Care: 40%	Yes	Yes

(Benefit information continued on next page)

Description of Covered Health Service	Notification Required?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
NOTE: If you don't notify United HealthCare per notification requirements above, Benefits will be reduced by 50%; however the reduction in Benefits will not exceed Eligible Expenses for the Covered Health Service. This 50% reduction will not apply to your Out-of-Pocket Maximum.				
9. Infertility Services We will cover diagnostic testing to rule out a diagnosis, but once diagnosed treatment of infertility is not covered. Please also refer to Section 2: What's Not Covered—Exclusions under item L. Reproduction.	***Network*** No	10%	Yes	Yes
	Non-Network No	40%	Yes	Yes
10. Injections – (Allergy Shots & Serum) Benefits are available for injections received in a Physician's office when no other health service is received, for example allergy immunotherapy.	***Network*** No	10%	Yes	Yes
	Non-Network No	40%	Yes	Yes

Description of Covered Health Service	Notification Required?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
11. Maternity Services	**Network**			
Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications. There are special prenatal programs to help during Pregnancy. They are completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify United HealthCare during the first trimester, but no later than one month prior to the anticipated delivery date.	*Yes, if Inpatient Stay exceeds time frames.	10% for physician's maternity delivery/ postpartum charges.	Yes	Yes
Benefits for an Inpatient Stay : • ***According to Federally Mandated Guidelines we will pay** 48 hours for the mother and newborn child following a normal vaginal delivery. • ***According to Federally Mandated Guidelines we will pay** 96 hours for the mother and newborn child following a cesarean section delivery.	**Non-Network** *Yes, if Inpatient Stay exceeds time frames	40%	Yes	Yes

(Benefit information continued on next page)

Description of Covered Health Service	Notification Required?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames. Pre-existing conditions limitation does not apply to pregnancy. **Notify United HealthCare** **Please remember that you must notify United HealthCare as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than the time frames described. If you don't notify United HealthCare that the Inpatient Stay will be extended, your Benefits for the extended stay will be reduced by 50%; however the reduction in Benefits will not exceed Eligible Expenses for the Covered Health Service. This 50% reduction will not apply to your Out-of-Pocket Maximum.**				

Description of Covered Health Service	Notification Required?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
12. Mental Health and Substance Abuse Services - Outpatient Mental Health Services and Substance Abuse Services received on an outpatient basis in a provider's office or at an Alternate Facility, including: • Medication management. • Short-term individual, family and group therapeutic services (including intensive outpatient therapy). The first twelve visits do not require certification, after the twelfth visit 50% penalty applies if not certified. Network Benefits for Mental Health Services and/or Substance Abuse Services is limited to 50 visits per calendar year. Non-Network Benefits for Mental Health Services and/or Substance Abuse Services is limited to 25 visits per calendar year. Please remember that you must call and get authorization to receive these Benefits in advance of any treatment United Behavioral Health (UBH). The UBH phone number that appears on your ID card is 1-877-246-4195.	***Network*** Yes, after 12th visit ***Non-Network*** Yes, after 12th visit	10% 40%	Yes Yes	Yes Yes

Description of Covered Health Service	Notification Required?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
13. Mental Health and Substance Abuse Services – Partial Day Hospitalization and Intensive Outpatient	***Network*** Yes	10%	Yes	Yes
Limited to 60 days per calendar year, combined Partial Hospitalization/Intensive Outpatient, for a Network provider. Limited to 30 days per calendar year, combined Partial Hospitalization/Intensive Outpatient, for a Non-Network provider. **Notify United HealthCare** **Please remember that you must notify United HealthCare five business days before receiving services. If you don't notify United HealthCare, Benefits will be reduced by 50%; however the reduction in Benefits will not exceed Eligible Expenses for the Covered Health Service. This 50% reduction will not apply to your Out-of-Pocket Maximum.**	***Non-Network*** Yes	40%	Yes	Yes

Description of Covered Health Service	Notification Required?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
14. Mental Health and Substance Abuse Services - Inpatient **Authorization Required** Any combination of Network and Non-Network Benefits for Mental Health Services and/or Substance Abuse Services is limited to 30 days per calendar year. Please remember that you must call United Behavioral Health (UBH) and get authorization to receive these Benefits in advance of any treatment. The UBH phone number that appears on your ID card is 1-877-246-4195.	***Network*** You must call UBH to receive the Benefits.	10%	Yes	Yes
Without authorization, your Benefits for the extended stay will be reduced by 50%; however the reduction in Benefits will not exceed Eligible Expenses for the Covered Health Service. This 50% reduction will not apply to your out of pocket maximum.	***Non-Network*** You must call UBH to receive the Benefits.	40%	Yes	Yes
Network Benefits for Mental Health Services and Substance Abuse Services must be provided by or under the direction of UBH.. For Network Benefits, referrals to a Mental Health/Substance Abuse provider are at the sole discretion of UBH, who is responsible for coordinating all of your care. Contact UBH regarding Benefits for inpatient Mental Health Services and Substance Abuse Services.				

(Benefit information continued on next page)

Description of Covered Health Service	Notification Required?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Benefits include detoxification from abusive chemicals or substances that is limited to physical detoxification when necessary to protect your physical health and well-being. Services on an inpatient medical unit for acute detoxification are covered under the medical in-patient benefit. **For substance abuse coverage limited to 3 episodes per lifetime.**				
15. Ostomy Supplies Benefits for ostomy supplies include only the following: • Pouches, face plates and belts. • Irrigation sleeves, bags and catheters. • Skin barriers. • Urinary Catheters.	***Network*** No	10%	Yes	Yes
Benefits are not available for gauze, adhesive, adhesive remover, deodorant, pouch covers, or other items not listed above.	***Non-Network*** No	40%	Yes	Yes

Description of Covered Health Service	Notification Required?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
16. Outpatient Surgery, Diagnostic and Therapeutic Services				
A. Outpatient Surgery Covered Health Services for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility. **Benefits under this section must meet medical necessity guidelines, if you are unsure please contact Care Coordination.**	***Network*** No	10%	Yes	Yes
Benefits under this section include only the facility charge and the charge for supplies and equipment. Benefits for the surgeon fees related to outpatient surgery are described under *Professional Fees for Surgical and Medical Services.* When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services.*	***Non-Network*** No	40%	Yes	Yes

(Benefit information continued on next page)

Description of Covered Health Service	Notification Required?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
B. Outpatient Diagnostic/Therapeutic Services Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including: • Lab and radiology/X-ray. • Mammography testing. • CT scans • PET scans • MRI • Nuclear Medicine When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services*.	***Network*** No	10%	Yes	Yes
	Non-Network No	40%	Yes	Yes
17. Physician's Office Services **Covered Health Services for the diagnosis and treatment of a Sickness or Injury received in a Physician's office.**	***Network*** No	10%	Yes	Yes
• X-ray/lab services are subject to the deductible	***Non- Network*** No	40%	Yes	Yes

Description of Covered Health Service	Notification Required?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
18. Physician's Office Services – Wellness Care/Preventative Healthcare and Annual Gynecological Exams **Covered Health Services for preventive medical care.** **Preventive medical care includes**: • Preventive medical care. • Well-baby and well-child care. • Routine physical examinations. • Vision and hearing screenings. (Vision screenings do not include refractive examinations to detect vision impairment, for routine eye examination benefits, please refer to *Eye Examinations* earlier in this SPD.) • Immunizations. • Associated test and immunizations up to $500 per person per calendar year. • Routine Mammograms (covered in Physician's office or at a Hospital or Alternate Facility setting.	***Network*** No	No Coinsurance	No	No
	Non-Network	**Not Covered & No Benefits for preventive care.**		

Description of Covered Health Service	Notification Required?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
• Routine colonoscopy screenings for colorectal cancer for persons 50 or older. Does not apply to the $500 wellness limitation.	***Network*** No	10%	Yes	Yes
	Non-Network No	40%	Yes	Yes
19. Professional Fees for Surgical and Medical Services Professional fees for surgical procedures and other medical care received in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls.	***Network*** No	10%	Yes	Yes
When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services*.	***Non-Network*** No	40%	Yes	Yes

Description of Covered Health Service	Notification Required?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
20. Prosthetic Devices External prosthetic devices that replace a limb or an external body part, limited to: • Artificial arms, legs, feet and hands. • Artificial eyes, ears and noses. • Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. Benefits include mastectomy bras and lymphedema stockings for the arm, quantity limits apply. If more than one prosthetic device can meet your functional needs, Benefits are available only for the most cost-effective prosthetic device. Except for wigs and items required by the Women's Health and Cancer Rights Act of 1998, any combination of Network and Non-Network Benefits for prosthetic devices is limited to $50,000 per calendar year. This limit applies to the total amount that we will pay for prosthetic devices, and does not include any Coinsurance or Annual Deductible responsibility you may have.	***Network*** Yes ***Non-Network*** Yes	10% 40%	Yes Yes	Yes Yes

(Benefit information continued on next page)

Description of Covered Health Service	Notification Required?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Notify United HealthCare **Please remember that you must notify United HealthCare five business days before receiving services. If you don't notify United HealthCare, Benefits will be reduced by 50%; however the reduction in Benefits will not exceed Eligible Expenses for the Covered Health Service. This 50% reduction will not apply to your Out-of-Pocket Maximum**.				
21. Reconstructive Procedures Services for reconstructive procedures, when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The fact that physical appearance may change or improve as a result of a reconstructive procedure does not classify such surgery as a Cosmetic Procedure when a physical impairment exists, and the surgery restores or improves function. Cosmetic Services are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. (Benefit information continued on next page)	***Network*** Yes ***Non-Network*** Yes	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services, and Prosthetic Devices. Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services, and Prosthetic Devices.		

Description of Covered Health Service	Notification Required?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?

The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury,

Sickness or Congenital Anomaly does not classify surgery or other procedures done to relieve such consequences or behavior as a reconstructive procedure.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact United HealthCare at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

Notify United HealthCare

Please remember that you must notify United HealthCare five business days before receiving services. When you provide notification, United HealthCare can verify that the service is a reconstructive procedure rather than a Cosmetic Procedure. Cosmetic Procedures are always excluded from coverage.

(Benefit information continued on next page)

Description of Covered Health Service	Notification Required?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
If you don't notify United HealthCare, Benefits for reconstructive procedures will be reduced by 50%; however the reduction in Benefits will not exceed Eligible Expenses for the Covered Health Service. This 50% reduction will not apply to your Out-of-Pocket Maximum.				
22. Rehabilitation Services - Outpatient Therapy Short-term outpatient rehabilitation services for: • Physical therapy. • Occupational therapy. • Speech therapy. • Pulmonary rehabilitation therapy. • Cardiac rehabilitation therapy. • Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Physician. Limited up to 40 visits per calendar year. Benefits are available only for rehabilitation services that are expected to result in significant physical improvement in your condition within two months of the start of treatment. (Benefit information continued on next page)	***Network*** No ***Non-Network*** No	10% 40%	Yes Yes	Yes Yes

Description of Covered Health Service	Notification Required?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Please note that we will pay Benefits for speech therapy only when the speech impediment or speech dysfunction results from Injury, stroke, Congenital Anomaly or documented hearing loss.				
23. Skilled Nursing Facility Services for an Inpatient Stay in a Skilled Nursing Facility. Benefits are available for: • Services and supplies received during the Inpatient Stay. • Room and board in a Semi-private Room (a room with two or more beds).	***Network*** Yes	10%	Yes	Yes
Any combination of Network and Non-Network Benefits is limited to 45 days per calendar year. Please note that Benefits are available only for the care and treatment of an Injury or Sickness that would have otherwise required an Inpatient Stay in a Hospital.	***Non-Network***		**Not Covered**	

(Benefit information continued on next page)

Description of Covered Health Service	Notification Required?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Notify United HealthCare **Please remember that you must notify United HealthCare as follows:** • **For elective admissions: five business days before admission.** • **For non-elective admission: within one business day or the same day of admission.** • **For Emergency admissions: within one business day or the same day of admission, or as soon as is reasonably possible.** **If you don't notify United HealthCare, Benefits will be reduced by 50%; however the reduction in Benefits will not exceed Eligible Expenses for the Covered Health Service. This 50% reduction will not apply to your Out-of-Pocket Maximum.**				

Description of Covered Health Service	Notification Required?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
24. Spinal Treatment, Chiropractic and Osteopathic Manipulative Therapy Benefits for Spinal Treatment when provided by a Spinal Treatment provider in the provider's office. Benefits include diagnosis and related services and are limited to one visit and treatment per day. Any combination of Network and Non-Network Benefits for Spinal Treatment is limited to 20 visits per calendar year.	***Network*** No	10%	Yes	Yes
	Non-Network No	40%	Yes	Yes

Description of Covered Health Service	Notification Required?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
25. Transplantation Services Covered Health Services for the following organ and tissue transplants when ordered by a Physician. Transplantation services must be received at a Designated Facility. Benefits are available for the transplants listed below when the transplant meets the definition of a Covered Health Service, and is not an Experimental, Investigational or Unproven Service.	***Network*** Yes	10%	Yes	Yes
• Bone marrow transplants (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service. • Heart transplants. • Heart/lung transplants. • Lung transplants. • Kidney transplants. • Kidney/pancreas transplants. • Liver transplants. • Liver/small bowel transplants. Pancreas transplants. • Small bowel transplants.	***Non-Network*** **Non-Network Benefits are not available.**	**Non-Network Benefits are not available.**	**Non-Network Benefits are not available.**	**Non-Network Benefits are not available.**

(Benefit information continued on next page)

Description of Covered Health Service	Notification Required?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?

Benefits are also available for cornea transplants that are provided by a Network Physician at a Network Hospital. We do not require that cornea transplants be performed at a Designated Facility.

Organ or tissue transplants or multiple organ transplants other than those listed above are excluded from coverage.

Under the Plan there are specific guidelines regarding Benefits for transplant services. Contact the Claims Administrator at the telephone number on your ID card for information about these guidelines.

Transportation and Lodging

United HealthCare will assist the patient and family with travel and lodging arrangements when services are received from a Designated Facility. Expenses for travel, lodging and meals for the transplant recipient and a family member(s) are available under this Plan as follows:

- Transportation of the patient and one family member who is traveling on the same day(s) to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure or necessary post-discharge follow-up.

(Benefit information continued on next page)

Description of Covered Health Service	Notification Required?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
• Eligible Expenses for lodging and meals for the patient (while not confined) and one family member. Benefits are paid at a per diem rate of up to $50 for one person or up to $100 for two people. • Travel and lodging expenses are only available if the transplant recipient resides more than 50 miles from the Designated Facility. • If the patient is an Enrolled Dependent minor child, the transportation expenses of two family members will be covered and lodging and meal expenses will be reimbursed up to the $100 per diem rate. • There is a combined overall lifetime maximum Benefit of $10,000 per Covered Person for all transportation, lodging and meal expenses incurred by the transplant recipient and family member(s) and reimbursed under this Plan in connection with all transplant procedure. **Notify United HealthCare** **You must notify United HealthCare as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't notify United HealthCare, Benefits will be reduced by 50%; however the reduction in Benefits will not exceed Eligible Expenses for the Covered Health Service. This 50% reduction will not apply to your Out-of-Pocket Maximum**.				

Description of Covered Health Service	Notification Required?	Your Coinsurance Amount % Coinsurance amounts are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
26. Urgent Care Center Services Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office. Benefits are available as described under Physician's Office Services earlier in the SPD.	***Network*** No	10%	Yes	Yes
	Non-Network No	40%	Yes	Yes

Section 2: What's Not Covered--Exclusions

This section contains information about:

- How headings are used in this section.
- Medical services that are not covered. We call these Exclusions regardless of medical necessity. This section lists some (but not all) of the things the Plan does not cover at all, under any circumstances.

How We Use Headings in this Section

To help you find specific exclusions more easily, we use headings. The headings group services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath headings. A heading does not create, define, modify, limit or expand an exclusion.

To continue reading, go to right column on this page.

We Do Not Pay Benefits for Exclusions

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following are true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in (Section 1: What's Covered--Benefits), and do not apply to your Out-of-Pocket Maximum.

A. Alternative Treatments

1. Acupressure and acupuncture.
2. Aroma therapy.
3. Hypnotism.
4. Massage Therapy.
5. Rolfing.
6. Environmental Medicine services or homeopathic/ holistic/alternative medicine services, including visits, diagnostic testing, labs, medications, or procedures from Providers of these practices.
7. Other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.

To continue reading, go to left column on next page.

B. Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/Barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:

— Air conditioners.

— Air purifiers and filters.

— Batteries and battery chargers.

— Dehumidifiers.

— Humidifiers.

— Air cleaners and dust collection devices..

C. Dental

1. Dental care except as described in (Section 1: What's Covered--Benefits) under the heading *Dental Services - Accident Only*.
2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include all of the following:

— Extraction, restoration and replacement of teeth, including impacted wisdom teeth.

— Medical or surgical treatments of dental conditions.

— Services to improve dental clinical outcomes.

3. Dental implants or associated services such as bone grafts for the placement of dental implants.
4. Dental braces and Orthodontics.

To continue reading, go to right column on this page.

5. Dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia. The only exceptions to this are for any of the following:

— Transplant preparation.

— Initiation of immunosuppressives.

— The direct treatment of acute traumatic Injury, cancer or cleft palate, , except as described in (Section 1: What's Covered—Benefits) under the heading *Dental Services - Oral Care*.

6. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a Congenital Anomaly.
7. Alveoplasty; vestibuloplasty; apicoectomy; excision of mandibular tori or exostosis; occlusal devices or their adjustment; splints for bruxism (clenching or grinding of teeth).
8. Surgery, appliances or prostheses such as crowns, bridges or dentures; fillings; endodontic care; treatment of dental caries; excision of radicular cysts or granuloma; treatment of periodontal disease; except as noted; and associated charges with any non-covered dental or oral service or supply.

D. Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill.
2. Self-injectable medications. A limited number of drugs identified by the Plan as appropriate for self-injection are covered under your Prescription Drug benefit. However, most injectable medications are covered as medical benefits, subject to Co-insurance and the applicable Deductible. While for some Members self-injection may be medically appropriate, most Members will need to visit their Physicians' offices for injections and will receive coverage for their medications as medical benefits and not as Prescription Drug benefits.

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You can call your Pharmacy vendor to see if your medication is covered as a Prescription Drug benefit and to ask any related questions.

3. Non-injectable medications given in a Physician's office except as required in an Emergency.
4. Over the counter drugs and treatments.
5. Unit dose medications.
6. Infertility drugs/Reproduction medicines, with the exception of diagnostic testing to rule out a diagnosis.
7. Growth hormone.
8. Human chorionic gonadotropin (HCG) injections for infertility/reproductive medicine.
9. Mail order drugs.
10. Smoking cessation medications or services.
11. Any drug administered for any purpose other than therapeutic treatment of an illness or injury.

Please refer to your Pharmacy Benefits Handbook.

E. Experimental, Investigational or Unproven Services

Experimental, Investigational and Unproven Services are excluded. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition. The Plan will cover procedures and supplies associated with cancer clinical trials that meet guidelines defined by the agreement between the Georgia Cancer Coalition and the Department of Community Health.

To continue reading, go to right column on this page.

F. Foot Care

1. Routine foot care (including the cutting or removal of corns and calluses).
2 Nail trimming, cutting, or debriding, with the exception for diabetic foot care.
3. Hygienic and preventive maintenance foot care. Examples include the following:

— Cleaning and soaking the feet.

— Applying skin creams in order to maintain skin tone.

— Other services that are performed when there is not a localized illness, Injury or symptom involving the foot.

4. Treatment of flat feet, fallen arches and chronic foot strain.
5. Treatment of subluxation of the foot.
6. Foot care devices such as arch supports and orthotics.
7. Shoes and footwear of any kind, including diabetic shoes, unless permanently attached to a covered brace.

G. Medical Supplies and Appliances

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:

— Ace bandages.

— Gauze and dressings.

— Syringes.

— Diabetic test strips. **Please refer to Pharmacy Benefits Handbook.**

To continue reading, go to left column on next page.

3. Orthotic appliances that straighten or re-shape a body part (including cranial banding and some types of braces).
4. Tubings and masks are not covered except when used with Durable Medical Equipment as described in (Section 1: What's Covered--Benefits).
5. Hot and cold packs.
6. Breast pumps.
7. Blood pressure cuffs (unless related to dialysis).
8. Lift for scooters and wheelchairs, stair glides and elevators, and any other home modifications.
9. Devices and computers to assist in communication.
10. Vacuum erection devices (VED, erec aid) to stimulate the penis.
11. Duplication, upgrade or replacement of currently functioning equipment.

H. Mental Health/Substance Abuse

1. Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
2. Mental Health Services and Substance Abuse Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment or crisis intervention and stabilization.
3. Mental Health Services as treatment for insomnia and other sleep disorders, neurological disorders and other disorders with a known physical basis.
4. Treatment for conduct and impulse control disorders, personality disorders, paraphilias and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by UBH.

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5. Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.
6. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, and any court ordered treatment, unless medically necessary and unless authorized by UBH.
7. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance abuse disorders that, in the reasonable judgment of UBH, are any of the following:

— Not consistent with prevailing national standards of clinical practice for the treatment of such conditions.

— Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome.

— Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.

— Not consistent with UBH's level of care guidelines or best practices as modified from time to time.

UBH may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.

8. Recreational, educational or bio-feedback therapy, unless specifically approved by UBH, or any form of self-care or self-care help training or related diagnostic testing.
9. Marriage counseling, unless approved in advance by UBH and conducted by a UBH authorized provider.

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10. Pastoral counseling.
11. Services of a social worker, professional counselor psychiatric nurse specialist, or marriage and family therapist even if prescribed by a Physician, unless pre-authorized by UBH and conducted by a UBH network provider.
12. Smoking cessation programs.
13. Weight management programs not related to psychiatric condition.
14. Psychoanalysis, to complete degree or residency requirements.
15. Vocational or educational training/services and related psychological testing.
16. Hypnosis.
17. Any psychological testing not related to a mental health or substance abuse diagnosis.
18. Experimental treatment performed for research.
19. Therapy treatment for attention deficit disorders, except for diagnosis and medical management, learning disabilities, developmental delays (except as mandated by state law for treatment of autism) or for speech disorders (such as stuttering) not related to an acute illness.
20. Treatment of a condition resulting from mental retardation, academic skills disorder, developmental disorder (except for autism diagnosis and treatment as required by state law) or motor-skills disorder.
21. Treatment of a condition classified by a UBH Provider as situational, and classified in DSM as a V-code ailment if there's no additional diagnosis to indicate a psychiatric ailment.
22. Family therapy when patient is not present.
23. Residential treatment, sub-Acute care; services of halfway house, supervised group home or boarding school.

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I. Nutrition

1. Megavitamin and nutrition based therapy. Vitamins, diet supplements, "blenderized" foods or nutritional products such as Isocal, Osmolite or Ensure.
2. Nutritional counseling for either individuals or groups, unless approved by UHC through DSM Programs.
3. Enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk.
4. Minerals or metabolic deficiency formulas.

J. Physical Appearance

1. Cosmetic Procedures. See the definition in (Section 11: Glossary of Defined Terms). Examples include:

— Pharmacological regimens, nutritional procedures or treatments.

— Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).

— Skin abrasion procedures performed as a treatment for acne.

2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure.
   Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in (Section 1: What's Covered--Benefits).
3. Physical conditioning programs such as athletic training, body-building, exercise and exercise equipment, fitness, flexibility, and diversion or general motivation.
4. Weight loss programs and dietary supplements whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.

To continue reading, go to left column on next page.

5. Treatment of hair loss. including wigs, medication or hair replacement, except diagnostic lab tests performed during initial diagnosis.
6. Hair removal, including electrolysis.
7. Blepharoplasty(upper or lower eyelid), browplasty, brow lift
8. Sclerotherapy and other related services.

K. Providers

1. Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal residence.
3. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services that are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:

— Has not been actively involved in your medical care prior to ordering the service, or

— Is not actively involved in your medical care after the service is received.

This exclusion does not apply to mammography testing.

4. Charges for professional services not rendered by the billing Provider.

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L. Reproduction

1. In vitro fertilization, gamete intrafallopian transfer (GIFT) procedures, and zygote intrafallopian transfer (ZIFT) procedures and any other reproductive technology.
2. Surrogate parenting.
3. The reversal of voluntary sterilization.
4. Infertility monitoring, correction or treatment, including drugs, in-vitro fertilization and other reproductive technologies.
5. Storage of egg, sperm or blood product for future use.
6. Infertility drugs and reproductive medicines.

M. Services Provided under Another Plan

1. Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation, no-fault auto insurance, or similar legislation.

   If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.
2. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
3. Health services while on active military duty.

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N. Transplants

1. Health services for organ, multiple and tissue transplants, except those described in (Section 1: What's Covered--Benefits).
2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's Benefits under the Plan).
3. Health services and expenses for transplants involving artificial, mechanical or animal organs.
4. Transplant services that are not performed at a Designated Facility.
5. Any solid organ transplant that is performed as a treatment for cancer.
6. Any multiple organ transplant not listed as a Covered Health Service under the heading *Transplantation Health Services* in (Section 1: What's Covered--Benefits).
7. Lodging related, except as defined in (Section 1: What's Covered –Benefits *Transplantation Services*), to the donation or transplantation of an organ.
8. Expenses for an artificial, mechanical or animal organ transplant.
9. Transplant therapy used as a palliatative procedure. Transplant therapy considered experimental, please refer to Section E.

O. Travel

1. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to covered transplantation services may be reimbursed as outlined in the Transplantation Service Section.

To continue reading, go to right column on this page.

P. Vision and Hearing

1. Purchase cost of hearing aids, eye glasses or contact lenses.
2. Fitting charge for hearing aids, eye glasses or contact lenses.
3. Eye exercise therapy, orthoptic training.
4. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, LASIK and other refractive eye surgery.
5. Diagnosis, treatment or surgical and non-surgical correction of far-sightedness, near-sightedness or astigmatism. Any vision care, including low-vision and other vision aids.
6. Tinnitis therapy, including sound generators.

Q. All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in (Section 11: Glossary of Defined Terms).
2. Physical, psychiatric or psychological exams, testing, therapy, vaccinations, immunizations or treatments that are otherwise covered under the Plan when:

— Required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption.

— Related to judicial or administrative proceedings or orders.

— Conducted for purposes of medical research.

— Required to obtain or maintain a license of any type.

3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.

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4. Health services received after the date your coverage under the Plan ends, including health services for medical conditions arising before the date your coverage under the Plan ends.
5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan.
6. In the event that a non-Contracted provider waives Coinsurances and/or the Annual Deductible for a particular health service, no Benefits are provided for the health service for which the Coinsurances and/or Annual Deductible are waived.
7. Charges in excess of Eligible Expenses or in excess of any specified limitation.
8. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), unless otherwise specified in the TMJ section.
9. Upper and lower jawbone surgery except as required for direct treatment of acute traumatic injury or cancer. Orthognathic surgery, jaw alignment and treatment for the temporomandibular joint, except as a treatment of obstructive sleep apnea, ,except as defined (Section 1: What's Covered – TMJ)
10. Non-surgical treatment of obesity, including morbid obesity, for example Optifast.
11. Medical and/or surgical treatment of obesity including, but not limited to, severe morbid obesity, gastric restrictive procedures and gastric bypass procedures.
12. Abdominoplasty, repair of diastasis recti, tummy tuck, excision of excessive skin and/or subcutaneous tissue, and liposuction.
13. Growth hormone therapy.
14. Sex transformation operations.
15. Custodial Care.
16. Domiciliary care.

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17. Private duty nursing.
18. Respite care.
19. Rest cures.
20. Psychosurgery.
21. Treatment of benign gynecomastia (abnormal breast enlargement in males).
22. Medical and surgical treatment of excessive sweating (hyperhidrosis).
23. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
24. Oral appliances for snoring.
25. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, Congenital Anomaly, or documented hearing loss..
26. Any charges for missed appointments, room or facility reservations, completion of claim forms, record processing, cost of obtaining or copying of medical records.
27. Any charge for services, supplies or equipment advertised by the provider as free.
28. Any charges prohibited by federal anti-kickback or self-referral statutes.
29. Therapy for non-covered diagnoses.
30. Re-habituation therapy.
31. Rehabilitation, rehabilitative therapy or restorative therapy, unless significant improvement is expected within a reasonable and generally predictable period of time following an acute illness.
32. Transitional living programs, day-treatment programs, cognitive remediation therapy.

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33. Specific needs-enhancement therapy for education, employment or motivation.
34. Educational evaluations or neurolinguistcal programming.
35. Lab charges and other charges not related to spinal care, when provided by a Spinal Treatment provider.
36. DME, except for certain neck and back braces when provided by a Spinal Treatment provider.
37. Vax-D therapy.
38. Not all preventative lab tests or diagnostic tests are covered under the Plan's Wellness benefit – even if that test or procedure was prescribed by a Participating Physician. For coverage information on a specific test and whether or not it is covered under the Plan's wellness benefit, contact your Physician before receiving the tests and ask for the current procedural terminology (CPT) code, then call Member Services.
39. Any item not specified in this list of exclusions that the Plan decides to limit based on its policies.

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Section 3: Description of Network and Non-Network Benefits

This section includes information about:

- Network Benefits.
- Non-Network Benefits.
- Your responsibility for notification.
- Emergency Health Services.

Network Benefits

Network Benefits are generally paid at a higher level than Non-Network Benefits. Network Benefits are payable for Covered Health Services which are:

- Provided by a Network Physician or other Contracted provider.
- Emergency Health Services.
- Covered Health Services that are described as Network Benefits in (Section 1: What's Covered--Benefits).
- The deductible applies to everything except the first $500 in preventative care expenses. If you have family coverage, you must meet the family deductible before benefits are payable for any family member.
- With the High Deductible Health Plan, you pay coinsurance after the deductible for in-network office visits and prescription drugs.

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Please note that Mental Health and Substance Abuse Services must be authorized by UBH. Please see (Section 1: What's Covered--Benefits) under the heading for *Mental Health and Substance Abuse*.

Comparison of Network and Non-Network Benefits

	Network	Non-Network
Benefits	A higher level of Benefits means less cost to you. See (Section 1: What's Covered--Benefits).	A lower level of Benefits means more cost to you. See (Section 1: What's Covered--Benefits).
Who Should Notify United HealthCare for Care Coordination	You must notify United HealthCare for certain Covered Health Services. Failure to notify results in reduced Benefits or no Benefits. See (Section 1: What's Covered--Benefits), under the *Notify United HealthCare?* column.	You must notify United HealthCare for certain Covered Health Services. Failure to notify results in reduced Benefits or no Benefits. See (Section 1: What's Covered--Benefits), under the *Notify United HealthCare?* column.
Who Should File Claims	Not required. We pay Contracted providers directly.	You must file claims. See (Section 6: How to File a Claim).

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	Network	Non-Network
Outpatient Emergency Health Services	Emergency Health Services are always paid as a Network Benefit (paid at the same level of benefit whether you are in or out of the Network). However, if care is rendered by a non-Network provider, you may be subject to balanced billing.	

Provider Network

United HealthCare arranges for health care providers to participate in a Network. Contracted providers are independent practitioners. They are not our employees or employees of United HealthCare. It is your responsibility to select your provider.

The credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status is subject to change. You can verify the provider's status by calling United HealthCare or by referring to the **www.myuhc.com website.**

It is possible that you might not be able to obtain services from a particular Contracted provider. If a provider leaves the Network or is otherwise not available to you, you must choose another Contracted provider to get Network Benefits.

Do not assume that a Contracted provider's agreement includes all Covered Health Services. Some Contracted providers agree to provide only certain Covered Health Services, but not all Covered Health Services. Some Contracted providers choose to be a Contracted provider for only some products. Refer to your provider directory or contact United HealthCare for assistance.

To continue reading, go to right column on this page.

Designated Facilities and Other Providers

If you have a medical condition that United HealthCare believes needs special services, they may direct you to a Designated Facility or other provider chosen by them. If you require certain complex Covered Health Services for which expertise is limited, United HealthCare may direct you to a non-Network facility or provider.

In both cases, Network Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility or other provider chosen by United HealthCare.

You or your Network Physician must notify United HealthCare of special service needs (including, but not limited to, transplants or cancer treatment) that might warrant referral to a Designated Facility or non-Network Facility or provider. If you do not notify United HealthCare in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Contracted provider, Network Benefits will not be paid. Non-Network Benefits may be available if the special needs services you receive are Covered Health Services for which Benefits are provided under the Plan.

Hospital Based Physicians

Non-participating Physicians sometimes practice in PPO network Hospitals. As a result, you may receive care in a network Hospital from a non-participating Hospital-based Physician, including providers such as emergency room Physicians, hospitalists, pathologists, radiologists, or anesthesiologists.

Covered Services from non-participating Hospital-based Physicians received in a network Hospital will be covered at the Non-Network benefit level.

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Non-Network Benefits

Non-Network Benefits are generally paid at a lower level than Network Benefits. Non-Network Benefits are payable for Covered Health Services that are provided by non-Network Physicians or non-Contracted providers. Non-Network Benefits are also payable for Covered Health Services that are provided at non-Network facilities.

Depending on the geographic area and the service you receive, you may have access through the United Healthcare's Shared Savings Program to providers who have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from these providers your Coinsurance will remain the same as it is when you receive Covered Health Services from non-Contracted providers who have not agreed to discount their charges; however, the total that you owe may be less when you receive Covered Health Services from Shared Savings Program providers than from other non-Contracted providers, because the Eligible Expense may be a lesser amount.

Your Responsibility for Notification

You must notify United HealthCare before getting certain Covered Health Services from either Network or non-Contracted providers. The details are shown in the *Prior Notification?* column in (Section 1: What's Covered--Benefits). If you fail to notify United HealthCare, Benefits are reduced or denied.

You do not have to contact United Healthcare if you have primary coverage from a different group health plan. However, if your primary health plan does not cover a procedure that requires Notification, then you must contact United Healthcare.

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Prior notification does not mean Benefits are payable in all cases. Coverage depends on the Covered Health Services that are actually rendered, your eligibility status, and any benefit limitations.

Care Coordination[SM]

When you notify United HealthCare as described above, they will work with you to implement the Care Coordination[SM] process and to provide you with information about additional services that are available to you, such as disease management programs, health education, pre-admission counseling and patient advocacy.

Emergency Health Services

We provide Benefits for Emergency Health Services when required for stabilization and initiation of treatment as provided by or under the direction of a Physician. Non Emergency use of the Emergency room is not covered.

Network Benefits are paid for Emergency Health Services, even if the services are provided by a non-Contracted provider.

If you are confined in a non-Network Hospital after you receive Emergency Health Services, United HealthCare must be notified within one business day or on the same day of admission if reasonably possible. United HealthCare may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-Network Hospital after the date United HealthCare decides a transfer is medically appropriate, Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.

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Your Health Savings Account (HSA) Opportunity

An HSA is like a personal savings account for healthcare, except it's all tax-free. When you enroll in the High Deductible Health Plan (HDHP), you may be eligible to open a HSA with an independent HSA administrator/custodian. You will need to contact a local bank or other financial organization to set-up your HSA Account.

Your HSA is yours and is not provided by the SHBP. The SHBP does not sponsor your HSA and does not establish it for you. You may open a HSA if you enroll in the HDHP and do not have other coverage- through your spouse's employer's plan, Medicare, Medicaid, a full unrestricted Health Care Savings Account (HCSA) – or any other medical plan.

HSA Highlights	
What you can contribute each year	Up to HDHP deductible amount: • $1,100 if you have individual coverage • $2,200 if you have family coverage as long as you continue to be enrolled in the HDHP. If you are 55 or older, you may contribute additional dollars – up to $700/year – as "catch-up" contributions
How you contribute	Through deposits you make directly to the HSA administrator you select…either in a lump sum or in installments throughout the year. Payroll deductions may be available through your employer.
What you can use your HSA to pay	Healthcare expenses (medical, dental, vision, over-the-counter medications) the IRS considers tax-deductible that aren't covered by any healthcare plan…see IRS Publication 502 at www.irs.gov.
How claims are paid	Varies based on HSA administrator, but generally you can pay expenses directly from your account (using a debit card or convenience checks), so there's no claim paperwork to submit
What happens at the end of the year	Unused money in your account carries forward and continues to earn interest
What happens if you don't enroll in the HDHP next year or leave your employer	You can no longer contribute to your HSA, but you keep the account and can continue to use the balance for eligible healthcare expenses

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Section 4: When Coverage Begins

This section includes information about:

- How to enroll.
- If you are hospitalized when this coverage begins.
- Who is eligible for coverage.
- When to enroll.
- When coverage begins.

How to Enroll

To enroll, the Eligible Person must complete an enrollment form. SHBP or its designee will give the necessary forms to you, along with instructions about submitting your enrollment form and any required contribution for coverage. SHBP will not provide Benefits for health services that you receive before your effective date of coverage.

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If You Are Hospitalized When Your Coverage Begins

If you are inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, SHBP will pay Benefits for Covered Health Services related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Plan.

You should notify United HealthCare within 48 hours of the day your coverage begins, or as soon as reasonably possible. In-Network Benefits are available only if you receive Covered Health Services from Contracted providers.

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Who is Eligible for Coverage

Who	Description	Who Determines Eligibility
Eligible Person	You are eligible to enroll yourself and your eligible dependents for coverage if you are: • **A Full-time employee of the State of Georgia, the General Assembly or an agency, board, commission, department, county administration or contracted employer that participates in SHBP, as long as:** — You work at least 30 hours a week consistently, and — Your employment is expected to last at least nine months. Not Eligible: Student employees or seasonal, part-time, or short-term employees. • **A certified public school teacher or library employee who works half-time or more, but not less than 18 hours a week.** Not Eligible: Temporary or emergency employees. • **A non-certified service employee of a local school system who is eligible to participate in the Teachers Retirement System** or its local equivalent. You must also work at least 60% of a standard schedule for your position, but not less than 20 hours a week. • **An employee who is eligible to participate in the Public School Employees' Retirement System** as defined by Paragraph 20 of Section 47-4-2 of the Official Code of Georgia, Annotated. You must also work at least 60% of a standard schedule for your position, but not less than 15 hours a week.	SHBP determines who is eligible to enroll under the Plan.

- **A retired employee of one of these listed groups** who was enrolled in the Plan at retirement and is eligible to receive an annuity benefit from a state-sponsored or state-related retirement system. **See Provisions for Eligible Retirees** for details of retiree medical coverage.
- **An employee in other groups** as defined by law.

Dependent

Eligible dependents are:

- **Your legally married spouse**
- **Your never-married dependent children who are:**

  (1) **Natural or legally adopted children under age 19**, unless they are eligible for coverage as employees. Children that are legally adopted through the judicial courts become eligible only after they are placed in your physical custody.

  (2) **Stepchildren under age 19 who live with you** at least 180 days per year and for whom you can provide documentation satisfactory to the Plan that they are your dependents.

  (3) **Other children under 19** if they live with you permanently and legally depend on you for financial support – as long as you have a court order, judgment or other satisfactory proof from a court of competent jurisdiction.

  (4) **Your natural children, legally adopted children or stepchildren 19 or older from categories 1 and 2** above who are physically or mentally disabled prior to reaching age 19 and who depend on you for primary support may continue their existing Plan coverage past age 19.

SHBP determines who qualifies as a Dependent.

Who	Description	Who Determines Eligibility
	(5) **Your natural children, legally adopted children, stepchildren or other children age 19 to 26 from categories 1, 2 and 3 above** who are registered Full-time Students at fully accredited schools, colleges, universities, or nurse training institutions and, if employed, who are not eligible for a medical benefit plan from their employer. The number of credit hours required for Full-time Student status is defined by the school in which the child is enrolled. When requested by the Plan, you will be required to provide copies of certified documents such as a marriage license, birth certificate, adoption contract or judge-signed court order to verify your dependent relationship. The Plan has the right to determine whether or not the documentation satisfies Plan requirements. If verification cannot be made, the dependent's coverage will be terminated retroactively to his or her coverage effective date. The Plan will make every effort allowable under the law to recover from the Participant any and all payments made by the Plan on behalf of an ineligible dependent.	

Documentation Required For Eligible Covered Dependents Age 19 or Older

Coverage does not continue automatically at age 19. This chart describes what you must do to request continued coverage as your child nears age 19.

Who	Description	Who Determines Eligibility
	For a Covered Dependent age 19 & older… ▪ … and a Full-time Student under the age 26 You must: ▪ update SHBP annually on student status by requesting a *certification letter* from the school's registrar and sending it with a *Dependent Student Status Information Form* to SHBP ▪ The certification letter must include: — enrollment date(s) for both current and previous quarters or semesters — number of credit-hours taken each quarter or semester — enrollment status (full- or part-time) for each quarter of semester	
	For a Covered Dependent age 19 & older… ▪ … and disabled as a covered SHBP Member before age 19 You must: ▪ file a written request for continuation of coverage prior to the 19th birthday or within 90 days after the 19th birthday and provide satisfactory documentation of disability If you have a disabled child who is already age 19 when you enroll, the child is not eligible for coverage. However, if your disabled child loses coverage under another plan, you may apply for SHBP coverage on the child if the child *were eligible for SHBP coverage on your child's 19th birthday.* To apply, send the Plan a written request and documentation on your child's disability and loss of other coverage within 90 days of the dependent's loss of coverage. You must be a Member when application is made.	

Who	Description	Who Determines Eligibility
	A general note regarding documentation sent to the Plan: While the Plan requires that coverage requests are made within a specific time period, the documentation required *to support your request* may be filed later, if necessary within the 60 days following the deadline to file the coverage request.	
	Qualified Medical Child Support Order (QMCSO) SHBP will honor a QMCSO for eligible dependents. A QMCSO creates, recognizes, or assigns the right for a dependent to receive benefits under a health plan. See *Glossary of Key Terms* and *Coverage Changes At Qualifying Events* for more information.	
	Who's Not Eligible For Dependent Coverage The most common examples of persons not eligible for SHBP dependent coverage include: • Your former spouse • Your fiancé • Your parents • Married or formerly married children • Children age 19 or older who do not qualify as Full-time Students or disabled dependents • Children 26 or older who are not already covered as a disabled dependent • Children in military service • Grandchildren who cannot be considered eligible dependents	

Who	Description	Who Determines Eligibility
	• Stepchildren who do not live in your home at least 180 days per year • Anyone living in you home that is not related by marriage or birth, unless otherwise noted	

When to Enroll and When Coverage Begins

You *must* enroll to have SHBP coverage. To enroll, go to your personnel/payroll office for instructions. You will be asked to:

- Choose a coverage option
- Select either single coverage or family coverage
- Name the eligible dependents you want to cover

Your signature on the enrollment form authorizes periodic payroll deductions for premiums. Your employer may also ask you to complete other forms. Once you make your coverage election, changes are not allowed outside the Open Enrollment period, unless you have a qualified change in status under Section 125 of the Internal Revenue Code, which restricts mid-year changes to coverage in the SHBP.

Special Note: If you terminate employment and are re-hired during the same Plan year, you must enroll in the same Plan option, provided you are eligible for that option.

Important Plan Membership Terms

The Plan uses these terms to describe Plan Membership:

- Participant – You, the contract/policy holder
- Member – You and/or your eligible dependents that you choose to enroll

Where appropriate, this SPD relies on these terms throughout the document:

- Employee, retiree or Member… to refer to Participant
- Dependent(s)… to refer to Member

When to Enroll	Who Can Enroll	
Initial Enrollment Period The Initial Enrollment Period is the first period of time when Eligible Persons can enroll.	Eligible Persons may enroll themselves and their Dependents.	Coverage begins on the date identified by the SHBP, if the SHBP receives the completed enrollment form and any required contribution for coverage within 31 days of the date the Eligible Person becomes eligible to enroll.
Open Enrollment Period	Eligible Persons may enroll themselves and their Dependents.	The SHBP determines the Open Enrollment Period. Coverage begins on the date identified by the SHBP if the SHBP receives the completed enrollment form and any required contribution within 31 days of the date the Eligible Person becomes eligible to enroll.

If you are:	You can enroll:	Your coverage takes effect:
▪ A current employee	▪ Or make coverage changes during Open Enrollment	▪ The upcoming January 1
	▪ Or make coverage changes within 31 days of a qualifying event; upon loss of all eligible dependents, within 90 days	▪ First of the month following request
▪ A newly hired employee	▪ Within 31 days of your hire date	▪ First of the month after a full calendar month of employment

If You Have Coverage through a Different Health Plan

If you elect to decline SHBP coverage, you must complete a Declination Form, available from your personnel/payroll office, and file it within 31 days of your hire date. You may not enroll until the next Open Enrollment period – unless you have a qualifying event.

Enrolling A Newly Eligible Dependent

If you have a new dependent due to marriage, birth or adoption, you may enroll your dependent if you request enrollment within 31 days of the marriage, birth or adoption.

This next chart describes what you need to do if you wish to add a newly eligible dependent.

	If you have to enroll a newly eligible dependent and…	You will need to:
Newly Eligible Dependent	… you already have family coverage	File a *Dependent/Miscellaneous Update Form* with SHBP, within 31 days of the birth, marriage or adoption
	… you do *not* have family coverage	Change your coverage type to family* by filing a *Membership Form* with your personnel/payroll office, within 31 days of the birth, marriage or adoption
	… you have a court order requiring you to enroll dependent child(ren)	Enroll the eligible child(ren); coverage starts on first day of month following the request. Change to family coverage if you have single coverage

**To make coverage retroactive to the child's birth or placement, you must make family coverage premium payment(s) for coverage for the month of the birth or adoption contract and placement.*

Identification Cards

After you enroll, you will receive an identification (ID) card for yourself and eligible dependent(s), if applicable. The ID card must be presented when care is received.

If you do not receive your ID card within two weeks of enrollment, please contact United HealthCare Insurance Company Customer Service at 877-246-4195.

When Coverage Begins

For You

When your coverage starts depends on when you enroll and when you make requests that affect your coverage.

If you enroll:	Your coverage begins:
During an Open Enrollment period	On January 1 of the new Plan Year
As a new employee	On the first day of the month following one full calendar month of employment
When you are reinstated or return to work from an unpaid leave of absence that occurred during the Open Enrollment period	On the first day of the month following the request or, if a judicial reinstatement, on the day specified in the settlement agreement
When you have a qualifying event	On the first day of the month following the request

Transferring Employees

If you are transferring between participating employers:

- Contact your new employer to coordinate continuous coverage
- You must continue the same coverage, unless you had a qualifying event that made you ineligible to continue that coverage

There is no coverage lapse when your employment break is less than one calendar month and your new employer deducts the premium from your first paycheck.

For Your Dependents

When you select family coverage as a new employee, dependent coverage begins when your coverage begins. If you add dependents later, coverage takes effect as described in the chart below:

If you add this dependent…	Coverage takes effect:
A baby Copy of certified birth certificate required upon request	On the first day of the month following the request; or On the day your child was born, if the family premium is paid from the birth month.
An adopted child Copy of certified adoption certificate required upon request	*When you already have family coverage:* • On the date of legal placement and physical custody, if the family premium is paid from the time of placement and custody *When you change to family coverage within 31 days of the event* • On the date of legal placement and physical custody, if the family premium is paid from the time of placement and custody

If you add this dependent…	Coverage takes effect:
A new spouse	*When you already have family coverage:* • On the day of your marriage *When you have single coverage:* • On the first day of the month following the request.
Stepchild(ren) Copy of certified birth certificate showing your spouse is the natural parent; and copy of certified marriage license showing the natural parent is your spouse; and notarized statement that dependent lives in your home at least 180 days per year	*When you have single coverage:* • On the first day of the month following the request *When you already have family coverage:* • On the first day of the month following the request.

Qualifying Events that Allow Coverage Changes for Active Participants

If you are an actively employed Participant and have one of the following qualifying events during the year, you may be able to make a coverage change that is consistent with the event. If you are a retiree, refer to the retiree section for permitted coverage changes. The following chart shows qualifying events and the corresponding changes that active Participants can make.

	If you have one of these events:	Within 31 days of event, you may:
	Marriage Certified copy of marriage certificate required	• Enroll • Change to family coverage • Discontinue coverage; letter from other plan documenting your coverage is required
	Birth, adoption or legal guardianship 1) Copy of certified birth or adoption certificate required 2) Copy of court decree showing your financial responsibility for the dependent; and copy of certified birth certificate; and notarized statement that dependent lives with you in your home on a permanent basis	• Enroll • Change to family coverage
	You lose coverage because of divorce Copy of divorce decree and loss of coverage documentation required	• Enroll in any available option • Change your coverage type

	If you have one of these events:	Within 31 days of event, you may:
	You or your spouse loses coverage through other employment Letter from other employer documenting loss required	• Change to family coverage
	You, your spouse, or enrolled dependent loses or discontinues health benefit coverage through other employment, Medicaid or Medicare Letter from other employer, Medicaid, or Medicare documenting time and reason for loss of discontinuation required	• Enroll in single or family coverage • Change to any available option
	Your spouse or your only enrolled dependent's employment status changes, resulting in a gain of coverage under a qualified plan Letter from other employer documenting affect on coverage eligibility required	• Change to single coverage • Discontinue coverage

	If you have one of these events:	Within 31 days of event, you may:
	Your former spouse loses coverage or plan is cancelled, resulting in loss of your dependent child(ren) coverage Letter from other plan documenting loss is required	• Enroll in any available option • Change to family coverage
	You acquire new coverage under spouse's employer's plan Letter from other plan documenting your coverage is required	• Change to single coverage • Discontinue coverage – you must document your spouse's coverage and current coverage for all dependents previously covered by your SHBP coverage
	Your spouse makes an Open Enrollment change under spouse's employer's plan, creating an overlap or break in coverage because spouse's coverage has a different plan year Letter from other plan documenting overlap or break in coverage is required	• Enroll • Change to single coverage • Discontinue your coverage - you must document your spouse's coverage

	If you have one of these events:	Within 31 days of event, you may:
	You or your spouse is activated into military reservist services Copy of orders required	• Enroll in any available option
	You retire and immediately qualify for a retirement annuity You must complete and submit Plan enrollment form no later than 60 days after leaving active employment	• Change to any available option or from family to single coverage when you retire
	You, your spouse, or all enrolled dependents become eligible for Medicare or Medicaid Letter from Medicare or Medicaid documenting eligibility required	• Discontinue your coverage • Change to single coverage – if you are retired and you discontinue your SHBP coverage when you enroll for Medicare, you won't be able to enroll again for SHBP coverage • Retirees may change to any available option upon becoming eligible for Medicare coverage.

If you lose all your Covered Dependents because of death, divorce, marriage of dependent, age, loss of full-time student status or other qualifying reason, you have *90 days from the date of the event* to complete the necessary form(s) to request a change from family to single coverage.

Qualified Medical Child Support Orders

If a QMCSO requires:	You can file a Membership Form to:
You to provide coverage for your natural child(ren).	• Enroll or change from single coverage to family coverage – there is no time limit for this change; documentation of the court order and the other coverage is required
Your former spouse to provide coverage for each of your enrolled natural child(ren)	• Change from family to single coverage – within 90 days of the court-ordered date; documentation of the court order and the other coverage is required

Generally, a change in coverage takes effect the first of the month following receipt of the change request.

Important Note on Coverage Changes:

If your current Plan option is not offered in the upcoming Plan Year and you do not elect a different option available to you during Open Enrollment or the Retiree Option Change Period, your coverage will be transferred automatically to the PPO Option effective January 1 of the subsequent Plan year.

How to Request a Change

During Open Enrollment and the Retiree Option Change Period, Members can go online to make coverage changes for the upcoming Plan Year. See the current *Health Plan Decision Guides* for Web addresses and instructions. If you do not have Internet access or if your request is in the middle of a Plan year, then:

- **Notify your personnel/payroll office.** Ask for the *Membership Form* and other required forms. If you are retired, contact the SHBP eligibility unit directly or your former employer's personnel office.
- **Return completed forms** with requested documentation to your personnel/payroll office, the SHBP or your retirement system. You must make your change by the appropriate deadline.

If you miss the deadline, you won't be able to make your change until the next Open Enrollment period. Changes permitted for retirees are limited, please refer to the retiree section for more details.

General Information about When Coverage Ends

We may discontinue this benefit Plan and/or all similar benefit plans at any time.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, we will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, we do not provide Benefits for health services that you receive for medical conditions that occurred after your coverage ended, even if the underlying medical condition occurred before your coverage ended.

An Enrolled Dependent's coverage ends on the date the Participant's coverage ends.

Events Ending Your Coverage

Coverage ends on the earliest of the dates specified in the following table:

For You

Your coverage generally will end if:

- You no longer qualify under any category listed under the eligibility rules and your payroll deductions for coverage have ceased.
- You do not make direct-pay premium payments on time
- You resign or otherwise end your employment
- You are laid off because of a formal plan to reduce staff
- Your hours are reduced so that you are no longer benefits eligible
- You do not return to active work after an approved unpaid leave of absence
- You are terminated by your employer

Coverage for Participant ends at the end of the month following the month in which the last premium is deducted from your earned paycheck or at the end of paid coverage. Premiums will not be deducted from final leave pay.

For Your Dependents

Coverage for your dependents will end at the same time you lose coverage because you are no longer eligible. Here are other situations that can affect coverage for you and your dependents.

	Situation	Effect on coverage
	If enrolled dependent is a stepchild under age 19 and does not meet the 180-day residency requirement	Coverage ends at the end of the month in which dependent moves out
	If enrolled dependent is a Full-time Student at an accredited college, university or other institution	Coverage ends on the last day of the month in which the earliest of these events occurs: • Graduation or completion of requirements if graduation is delayed • Full-time attendance ends – unless child has attended previous two consecutive semesters and plans to return after a one semester break • Dependent reaches age 26 • Dependent marries • Dependent becomes employed in a benefits-eligible position

Situation	Effect on coverage
If you divorce and your spouse loses coverage as your dependent*	• Coverage ends at the end of the month in which the divorce becomes final
If you or your spouse or eligible dependent(s) loses other group health insurance coverage because of change in employment	• Before you lose coverage or within 31 days after losing coverage, file request for SHBP coverage, which will start on the first day of the month following the request
If you declined coverage for yourself or your dependents because of other group health insurance coverage, and you later lose that coverage	• You may enroll yourself or you family if you request this coverage within 31 days of the event

* If you receive a court order to provide health coverage for a divorced spouse, you may temporarily continue Plan coverage for the divorced spouse by electing COBRA continuation coverage, which is limited to 36 months of coverage. You must request a COBRA information packet from the SHBP within 60 days of the event.

Coverage for a Disabled Child

Coverage for an unmarried Enrolled Dependent child who is not able to be self-supporting because of mental or a physical disability may not end just because the child has reached age 19. Consideration may be given for extension of coverage for that child beyond the age 19 if both of the following are true and certified by the Plan:

- Is not able to be self-supporting because of mental or physical disability.
- Depends mainly on the Participant for support.

Coverage will continue as long as the Enrolled Dependent is disabled and dependent unless coverage is otherwise terminated in accordance with the terms of the Plan.

We will ask you to furnish SHBP with proof of the child's disability and dependency within 90 days of the date coverage would otherwise have ended because the child reached age 19.

SHBP may continue to ask you for proof that the child continues to meet these conditions of disability and dependency.

If you do not provide proof of the child's disability and dependency within 90 days of SHBP's request as described above, coverage for that child will end.

Section 5: Provisions for Eligible Retirees & Considerations for Participants Near Retirement

Plan Membership

This section includes Plan Membership and co-ordination of benefits information for eligible retirees as well as important points to consider if you are near retirement. Effective January 1, 2006, SHBP will implement a new Medicare policy. SHBP will pay primary benefits for non-enrolled Medicare eligible retirees as well as retirees who are not entitled to Medicare because they did not participate in Social Security or pay Medicare taxes.

Eligibility

You may be able to continue Plan coverage if you are enrolled in the Plan when you retire and are immediately eligible to draw a retirement annuity from any of these systems:

- Employees' Retirement System
- Teachers Retirement System
- Public School Employees Retirement System
- Local School System Teachers Retirement Systems
- Fulton County Retirement System (eligible Members)
- Legislative Retirement System
- Superior Court Judges or District Attorney's Retirement System

Important Note: Individuals who have withdrawn money from their respective retirement system will not be able to continue health coverage as a retiree. Eligibility for temporary extended coverage under COBRA provisions would apply.

Applying for Coverage Continuation

If you are an eligible retiree, you must apply for continued coverage for yourself and Covered Dependents within 60 days of the date your active coverage ends. Application can be made on a *Retirement/Surviving Spouse Form,* available through your personnel/payroll office or by contacting the Plan's Eligibility Section. **Failure to apply timely or make the appropriate premium payments terminates your eligibility for retiree coverage.**

When Coverage Begins

If you are eligible for a monthly annuity at the time you retire, your coverage starts immediately at retirement, provided that you make proper premium payments or have them deducted from your annuity check. Coverage for your dependents (if you elect to continue dependent coverage) starts on the same day that your retiree coverage begins. A change from single to family coverage as a retiree is allowed only when you have a qualifying event.

When Coverage Ends:

For You

Coverage will end when you discontinue coverage or fail to pay premiums on time.

For Your Dependents

Coverage for your dependents will end when:

- They are no longer eligible
- You change from family to single coverage
- You do not pay premiums on time
- Your coverage as a Participants ends.

Keep in mind that if you drop dependents from your coverage, you will *not* be able to enroll them again – unless you have a qualifying event.

Continuing Dependent Coverage at Your Death

In the event of your death, your surviving spouse or eligible dependents should contact the applicable retirement system (ERS, TRS, PSERS, etc.) and the Plan as soon as possible. To continue coverage, surviving spouses or eligible children must complete a Retirement/Surviving Spouse Form and send it to the Plan within 90 days of your death.

Plan provisions vary for survivors:

Surviving spouse receives annuity

- Plan coverage may continue after your death
- Premiums will be deducted from annuity
- Spouse sends payments directly to Plan if annuity is not large enough to cover premium

Surviving spouse does not receive annuity

- Plan coverage may continue after your death when spouse was married to you at least one year before death
- Spouse sends payments directly to the Plan
- Coverage ends if surviving spouse remarries

Surviving child receives annuity

- Plan coverage may continue for each eligible child receiving an annuity larger than the Plan premium
- Member sends payments directly to Plan if annuity is not large enough to cover premium
- Surviving spouses may continue coverage by sending premiums to the Plan

Surviving child does not receive annuity and there is no surviving spouse

- Plan coverage may continue under COBRA provisions
- New dependents or spouses *cannot* be added to survivor's coverage
- Dependent child coverage ends when the child becomes ineligible

Making Changes to Your Retiree Coverage

You can make changes to your coverage only at these times:

- When you have a qualifying event
- During the annual Retiree Option Change Period
    - You may change your Plan option only
    - Adding dependents is not permitted unless you have a qualifying event as described in the section below.

Qualifying Events

	If you have this event…	You may…
	• Within 31 days of eligibility for retiree coverage • Annuity no longer covers premium amount • Become eligible for Medicare	Change to an available option
	• Acquire dependent because of marriage, birth, adoption or Qualified Medical Child Support Order (QMCSO) • Within 31 days of loss of a dependent's health benefit coverage through spouse's or former spouse's Medicaid, Medicare, group or COBRA coverage	Change from single to family coverage* Proper documentation is required **Surviving spouses and dependents cannot change from single to family coverage*
	• Spouse or enrolled dependent's employment status changes, affecting coverage eligibility under a qualified health plan	Change coverage type within 31 days of the qualifying event; proper documentation is required

If you have this event…	You may…
• You and spouse are both retirees who both have sufficient retirement benefits from a covered retirement system to have Plan premiums deducted	Change at any time from family coverage to each having single coverage; a request to change from family to single for you and the request for single coverage for your spouse must be filed at the same time

You must request a coverage change within 31 days of the qualifying event by:

- Contacting the Plan directly
- Returning the necessary form(s) with any requested documentation to the Plan by the deadline. Fill out the form(s) completely.

If you miss the deadline, you will not have another change to make the desired change. If the deadline is met, your change will take effect on the first day of the month following the receipt of your request.

Changes Permitted Without A Qualifying Event

Retirees may change from family to single coverage, or discontinue coverage at anytime by submitting the appropriate Plan form. However, if you change from family to single coverage, you cannot increase your coverage later without a qualifying event. Also, if you discontinued coverage, you may not enroll later.

Important Note On Coverage Changes: If your current Plan option is not offered in the upcoming Plan Year and you do not elect a different option available to you during the Retiree Option Change Period, your coverage will be transferred automatically to the PPO Option effective January 1 of the subsequent Plan Year.

Retiree Option Change Period

During the 30-day Retiree Option Change Period – generally from mid-October to mid-November each Plan Year – you can make these changes to your coverage:

- Select a new coverage option
- Change from family to single coverage
- Discontinue coverage (Note that re-enrollments are not allowed.)

Changes will take effect the following January 1.

Before the Retiree Option Change Period begins, the Plan will send you a retiree information packet. The packet will include:

- Information on the Plan options
- Steps for notifying the Plan about coverage selections for the new Plan Year
- Forms you may need to complete
- Informational resources.

To ensure that you receive the information packet, make sure the Plan always has your most up-to-date mailing address.

If You Return to Active Service

If you choose to return to active service with an employing entity under the Plan, whether immediately after you retire or at a later date, your retirement annuity may be suspended or continued. Health Plan coverage, however, must be purchased as an active employee and through payroll deduction by your employer. You will need to complete enrollment paperwork with your Employer and the appropriate form to have the deduction stopped with the retirement system.

When you return to retired status, retiree coverage may be reinstated after notifying the Plan within 60 days. You will be eligible for continuous coverage, based on the conditions that first made you eligible as a retiree.

If you retired before the initial legislative funding for a particular employee group, you will not be entitled to retiree Plan coverage – unless the final service period qualifies you for a retirement benefit from a state-supported retirement system.

Impact of Medicare on Benefits

Coordination of Benefits With Medicare

Medicare is the country's health insurance program for people age 65 or older who qualify based on Medicare eligibility rules. Medicare also covers certain people with disabilities who are under age 65 and people of any age who have permanent kidney failure.

To prevent duplicate benefit payment, the Plan coordinates benefits with Medicare and any other plan that may cover you and your dependents. The first step in coordination is the determination of which plan is primary – or which plan pays benefits first - and which plan is secondary. Under Georgia law, the SHBP is required to subordinate health benefits to Medicare benefits.

The chart below provides important details related to primary and secondary coverage based on your Medicare status:

	If you are retired and …	The Plan will pay…
	…age 65, Medicare-eligible and enrolled in Part A and Part B; consider enrolling prior to the month in which you turn 65 to maximize coverage	Secondary benefits starting on the first day of the month in which you turn 65
	…age 65, Medicare-eligible and do *not* enroll in Part A and Part B	Primary benefits; however, Plan premium will increase
	…age 65 or older and not entitled to Medicare	Primary benefits; however, Plan premium will increase

Section 6: How to File a Claim

This section provides you with information about:

- How and when to file a claim.
- If you receive Covered Health Services from a Contracted provider, you do not have to file a claim. We pay these providers directly.
- If you receive Covered Health Services from a non-Contracted provider, you are responsible for filing a claim and payment.

If You Receive Covered Health Services from a Contracted provider

We pay Contracted providers directly for your Covered Health Services. If a Contracted provider bills you for any Covered Health Service, contact United HealthCare. However, you are responsible for meeting the Annual Deductible and for paying Coinsurance to a Contracted provider at the time of service, or when you receive a bill from the provider.

To continue reading, go to right column on this page.

Filing a Claim for Benefits

When you receive Covered Health Services from a Non-contracted provider.

You must submit a request for payment of Benefits within 24 months following the month of service. If you do not submit this information within the specified time limit the claim will not be paid. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the month of service is the date your Inpatient Stay ends.

Pharmacy Benefit Claims

Please refer to the Outpatient Prescription Drug Rider.

Required Information

When you request payment of Benefits from us, you must provide all of the following information:

A. Participant's name and address.
B. The patient's name, age and relationship to the Participant.
C. The member number stated on your ID card.
D. An itemized bill from your provider that includes the following:

— Patient diagnosis
— Date of service
— Procedure code(s) and description of service(s) rendered
— Provider of service (Name, Address and Tax Identification Number)

E. The date the Injury or Sickness began.

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F. A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

Payment of Benefits

Through United HealthCare, we will make a benefit determination as set forth below.

You may assign your Benefits under the Plan to a non-Contracted provider.

United HealthCare will notify you if additional information is needed to process the claim. United HealthCare may request a one time extension not longer than 15 days and will pend your claim until all information is received. Once you are notified of the extension or missing information, you then have at least 45 days to provide this information.

Benefit Determinations

Post-Service Claims

Post-Service Claims are those claims that are filed for payment of benefits after medical care has been received. If your post-service claim is denied, you will receive a written notice from United HealthCare within 30 days of receipt of the claim, as long as all needed information was provided with the claim. United HealthCare will notify you within this 30-day period if additional information is needed to process the claim, and may request a one time extension not longer than 15 days and pend your claim until all information is received.

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Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame and the claim is denied, United HealthCare will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

Pre-Service Claims

Pre-service claims are those claims that require notification or approval prior to receiving the requested medical care. If your claim is a pre-service claim, and was submitted properly with all needed information, you will receive written notice of the pre-service claim decision from United HealthCare within 15 days of receipt of the claim. If you filed a pre-service claim improperly, United HealthCare will notify you of the improper filing and how to correct it within 5 days after the pre-service claim was received. If additional information is needed to process the pre-service claim, United HealthCare will notify you of the information needed within 15 days after the claim was received, and may request a one time extension not longer than 15 days and pend your claim until all information is received. Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, United HealthCare will notify you of the pre-determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied. A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

To continue reading, go to left column on next page.

Urgent Claims that Require Immediate Action

Urgent claims are those claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition could cause severe pain. In these situations:

- You will receive notice of the benefit determination in writing or electronically within 72 hours after United HealthCare receives all necessary information, taking into account the seriousness of your condition.
- Notice of denial may be oral with a written or electronic confirmation to follow within 3 days.

If you filed an urgent claim improperly, United HealthCare will notify you of the improper filing and how to correct it within 24 hours after the urgent claim was received. If additional information is needed to process the claim, United HealthCare will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.

You will be notified of a determination no later than 48 hours after:

- United HealthCare's receipt of the requested information; or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

Concurrent Care Claims

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If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent claim as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. United HealthCare will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent claim and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

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Section 7: Questions, Complaints and Appeals

This section provides you with information to help you with the following:

- You have a question or concern about Covered Health Services or your Benefits.
- You have a complaint.
- How to handle an appeal that requires immediate action.
- You are notified that a claim has been denied because it has been determined that a service or supply is excluded under the Plan and you wish to appeal such determination. Appeals should be sent to the following address:

  United HealthCare Insurance Company

  P.O. Box 30994

  Salt Lake City, Utah 84130-0432

If a request for Plan benefits is denied, either totally or partially, you or your dependents will receive a notice of denial either electronically or in writing – or, in case of Urgent Care, notice is verbal and then followed by an electronic or written notification. To resolve a question or appeal, just follow these steps:

To continue reading, go to right column on this page.

What to Do First

If your question or concern is about a benefit determination, you may informally contact Customer Service before requesting a formal appeal. The Customer Service telephone number is shown on your ID card and on page 2 of this SPD. If the Customer Service representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described in (Section 6: How to File a Claim) you may appeal it as described below, without first informally contacting Customer Service. If you first informally contact Customer Service and later wish to request a formal appeal in writing, you should contact Customer Service and request an appeal. If you request a formal appeal, a Customer Service representative will provide you with the appropriate address of United HealthCare to submit the written appeal.

If you are appealing an urgent care claim denial, please refer to the "Urgent Claim Appeals that Require Immediate Action" section below and contact Customer Service immediately.

How to Appeal a Claim Decision

If you disagree with a pre-service or post-service claim determination after following the above steps, you can contact United HealthCare in writing to formally request an appeal.

Your request should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.

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- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to United HealthCare within 180 days after you receive the claim denial.

Appeal Process – How to Appeal an Eligibility Decision

SHBP will handle all eligibility appeals. Please forward all eligibility appeals to: State Health Benefit Plan, Membership Correspondence Unit P.O. Box 38342, Atlanta, GA 30334. All Member correspondences sent to the Plan should include the Participant's Social Security Number (SSN). Including your SSN will help prevent delay in processing your requests.

Appeals Determinations

Pre-Service and Post-Service Claim Appeals

You will be provided written or electronic notification of decision on your appeal as follows:

For appeals of pre-service claims, as defined in (Section 6: How to File a Claim), the first level appeal will be conducted and you will be notified by United HealthCare of the decision within 15 days from receipt of a request for appeal of a denied claim.

The second level appeal will be conducted and you will be notified by United HealthCare of the decision within 15 days from receipt of a request for review of the first level appeal decision.

For appeals of post-service claims as defined in (Section 6: How to File a Claim), the first level appeal will be conducted and you will be notified by United HealthCare of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by United HealthCare of the decision within 30 days from receipt of a request for review of the first level appeal decision.

To continue reading, go to right column on this page.

For procedures associated with urgent claims, see "Urgent Claim Appeals that Require Immediate Action" below.

If you are not satisfied with the first level appeal decision of United HealthCare, you have the right to request a second level appeal from United HealthCare. Your second level appeal request must be submitted to United HealthCare in writing within 60 days from receipt of the first level appeal decision.

For pre-service and post-service claim appeals, SHBP has delegated to United HealthCare the exclusive right to interpret and administer the provisions of the Plan. United HealthCare's decisions are conclusive and binding.

Please note that United HealthCare's decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your Physician.

Urgent Claim Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations:

The appeal does not need to be submitted in writing. You or your Physician should call United HealthCare as soon as possible. United

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HealthCare will provide you with a written or electronic determination within 72 hours following receipt by United HealthCare of your request for review of the determination taking into account the seriousness of your condition.

For urgent claim appeals, we have delegated to United HealthCare the exclusive right to interpret and administer the provisions of the Plan. United HealthCare's decisions are conclusive and binding.

Voluntary External Review Program

If a final determination to deny Benefits is made, you may choose to participate in our voluntary external review program at your cost. The cost can range from $500 - $ 2,000. This program only applies if the decision is based on either of the following:

- Clinical reasons.
- The exclusion for Experimental, Investigational or Unproven Services.

The external review program is not available if the coverage determinations are based on explicit Benefit exclusions or defined Benefit limits. Therefore, the second level appeal decision is final.

Contact United HealthCare at the telephone number shown on your ID card and page 2 of this SPD for more information on the voluntary external review program.

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Section 8: Coordination of Benefits

This section provides you with information about:

- What you need to know when you have coverage under more than one plan.
- Definitions specific to Coordination of Benefit rules.
- Order of payment rules.

Filing a Claim When Coordination of Benefits (COB) applies

You and your Covered dependents may have medical coverage under more than one plan. In this case, the Plans coordination of benefits (COB) provisions apply.

When SHBP benefits are coordinated, the Plan does not pay more than 100% of the Plan's Allowed Amount. Non-Covered Services or items, penalties, and amounts Balance Billed are not part of the Allowed Amount and are the Participant's responsibility.

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- COB applies to group health coverage, including:

— Government programs such as Medicare or state contracts (dual SHBP coverage)

— Your spouse's insurance at his or her work

— COBRA coverage

- COB does not apply to an individual policy – one for which you pay the total premium directly to the insurer.

If the 24-month timely filing limit is approaching and you have not received an explanation of benefits (EOB) from the primary plan, submit your claim(s) to the Plan without the EOB prior to the deadline. When you receive the EOB, send it to the Plan for processing, even if the deadline has passed.

For COB information that applies when you or a Covered Dependent is injured in an accident caused by another party, see *Subrogation.*

How COB Works

- **When you or your dependents are covered by two group health plans, determine which plan is the primary and which is secondary.** The primary plan is obligated to pay a claim first, which generally means that it will pay most of the expenses.
- **Submit claims to the primary plan first.** You will receive a benefit payment from that plan along with an explanation of benefits (EOB).
- **Make a copy of the EOB you received from the primary plan, attach it to a claim form and mail both to the secondary plan.** The SHBP won't pay a secondary benefit until you submit the primary plan's EOB. Indicate the name and

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policy number of the person who has the other coverage and that plan's group number.

If your other group coverage ends, you must report the cancellation date to Member Services in writing and include supporting documentation from the primary plan. You can get the information from your employer or from the other insurance company.

How to Tell Which Plan is Primary

Generally, a plan is primary when:

- The patient is the Participant or employee
- The plan does not have coordination of benefits
- The plan is a Workman's Compensation Plan or an automobile insurance medical benefit
- The other plan is Medicare and the patient is covered under the group plan of an active employee. Those under the age 65 may qualify for Medicare because of a covered disability or end-stage renal disease. Your Plan coverage will be primary during the first part of your Medicare participation, then Medicare will become primary. Medicare determines the length of time Plan coverage is primary.

In other situations, determining which plan is primary is more complicated:

- **If the patient is a dependent child with married parents,** the plan that covers the parent whose birthday comes first in the Calendar year is primary, unless the parents are divorced. If both parents were born on the same date, the plan that has covered the parent for the longest time pays first.

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- **When a plan uses the gender rule to determine the primary plan, the father's plan is primary**. If the other plan follows the gender rule, the SHBP will allow the father's plan to be primary.
- **When the patient is a dependent child whose parents are divorced,** the plan of the parent with custody pays first, except where a court decrees otherwise.
- **If the parent with legal custody has remarried:**

— The plan of the parent with legal custody pays first.

— The Plan of the spouse of the parent of the parent with custody pays second.

— The plan of the parent who does not have custody pays last.

If custody is joint, the plan that covers the parent whose birthday comes first in the Calendar Year is primary.

- **When two plans cover the Member as an active employee,** the plan that has covered the employee the longest pays first.

- **For active employees versus inactive employees,** a plan that covers a person:

— As an active employee is primary over a plan that covers a person retired, laid off or covered under COBRA.

— As an inactive employee is primary over a plan that covers the inactive employee as the as the spouse of an active employee.

— As a dependent of an active employee is primary over Medicare coverage for a retiree.

If none of the rules described in this section apply, the plan that has covered the person the longest is primary.

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If You Have Dual Plan Coverage

Coordination of benefits when both you and your spouse have Plan coverage as Participants (i.e., when you have dual coverage) works like this:

- If one of you has family coverage and the other has single coverage, only the spouse with the single coverage has dual coverage.
- When both spouses have dual coverage, the coverage of the spouse who is the patient is primary.
- If the patient is a dependent, then the plan that covers the parent whose birthday comes first in the Calendar year is primary.

When you have dual coverage, you cannot transfer Deductibles between Plan contracts.

Other Forms of Duplicated Benefits

- The Plan does not duplicate payments that you may receive under third-party medical payment contracts or because of any lawsuit, including malpractice litigation.
- If you receive medical payments from underwriters of a homeowner's policy, an automobile insurance policy or any other payment plan, the Plan will consider only those charges over the amounts paid by the third party(ies).
- The Plan has the right to delay your payments until it determines whether or not other parties are liable for paying your medical expenses. However, when the employee or Covered Dependent must sue to determine the parties' obligations, the Plan will not delay payment-provided that you or the payee agrees to reimburse the Plan for duplicated medical payments.

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Section 9: Continuation of Coverage under COBRA

This section provides you with information about all of the following:

- Continuation of coverage under federal law (COBRA).

When Coverage may be Continued

Certain situations allow you to continue your SHBP coverage.

Unpaid Leaves of Absence

If you are an active employee on an approved unpaid leave, you may be able to continue your current coverage for up to 12 calendar months – or up to 18 calendar months for military leave.

Unpaid leave is available for:

- Disability/illness – more details below
- Educational instruction
- Employee's convenience
- Employer's convenience

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- Family medical reasons as provided under the Family and Medical Leave Act (FMLA) – more details below
- Military duty (emergency and voluntary) – more details below
- Suspension of employment

You will have to meet certain requirements for each leave type and your personnel/payroll office can provide you with the necessary information, including premium rates and a *Request to Continue Health Benefits During Leave of Absence Without Pay* form. Also, most leave types require supporting documentation.

You can apply for continued coverage within 31 days after starting an unpaid leave.

To continue reading, go to left column on next page.

Continuing Coverage During Approved Disability Leave

In case you become disabled while an active employee, the Plan has provisions that may allow you to continue coverage, which are described in the table below:

Because of a disability, you have this situation:	***You will be affected in this way:***
• You are Totally Disabled and are on an approved disability leave OR • You return to work on a part-time basis before the end of your approved disability leave and before returning to full-time work	• You will be eligible to continue health benefits for up to 12 months • You must pay premiums directly to SHBP • Coverage is limited to whichever is less: — The disability period that your Physician certifies you must provide additional documentation of your disability period — 12 consecutive months if the disability continues

If you are a disabled retired Member, see Provisions for the Eligible Retirees for more information on how your coverage may be affected.

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Continuing Coverage Under Family and Medical Leave Act (FMLA)

You may continue medical coverage for yourself and your dependents for up to 12 weeks for specific medical and/or family medical reasons. Forms for continuing your coverage are available from your personnel/payroll office.

During FMLA leave without pay, the SHBP will bill you directly for coverage premiums. How FMLA affects your coverage depends on the circumstances involving your leave.

If you have this situation:	***You will be affected in this way :***
• Choose not to continue coverage while on leave	• Claims will not be paid by SHBP for the period after coverage terminates and while you remain on leave. You are responsible for paying Providers. • You must resume coverage when you return to work.
• Open Enrollment period occurs while on leave	• If you continue coverage while on leave, you may change coverage as permitted during Open Enrollment • If you do not continue coverage while on leave, contact your employer for Open Enrollment information
• Do not return to work after your leave ends and you have paid your premiums directly to the Plan during your leave	• You may be eligible to continue your medical coverage through COBRA

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Continuing Coverage During Military Leave

You and your dependents have the right to continue your coverage for up to 18 months with premium payments sent directly to the SHBP.

- If you are an activated military reservist called on an emergency basis, you will pay your employee share of the premium.
- For other military leaves, you will be required to pay the full premium. Also, you will be charged a monthly processing fee.

You may elect to discontinue coverage while on leave. The SHBP will reinstate your coverage when you return from military service. However, for the time period allowed by the Veteran's Administration, the Plan does not cover care for a Participant's illness or injury that the Secretary of Veterans' Affairs determines was acquired or aggravated during the military leave.

If You Leave Your Job

This chart shows how your coverage would be affected if you were to leave your job:

If you have this situation:	***You will be affected in this way:***
• Leave your job with less than eight years of service • Take another job that does not qualify you for coverage • Move to part-time status • Are laid off	• You can continue coverage for up to 18 months under COBRA provisions
Leave your job and: • Have at least eight years of service, but less than 10 years	You can continue coverage by: • Submitting the appropriate forms(s) within 60 days of when your coverage would end • Paying the full cost of coverage, except Subscribers under the Legislative Retirement System • Providing a statement from your employer verifying your service

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If you have this situation:	*You will be affected in this way:*
Leave your job and: • Have at least 10 years of service, but before minimum age to qualify for an immediate retirement annuity • You leave money in retirement system	You can continue coverage by: • Submitting the appropriate forms(s) within 60 days of when your coverage would end • Paying the full cost of coverage until your annuity begins • Paying a lower Member premium once your annuity begins

See provisions for Eligible Retirees for more information about how coverage is affected when you leave your job and are immediately eligible to draw a retirement annuity.

In the Event of an Active Employee's Death

The benefits available to your survivors will depend on your length of service.

- When your surviving spouse receives an annuity from a qualifying retirement system, your covered survivor(s) can continue Plan coverage if your surviving spouse:

— Elects to receive his or her benefits as an annuity (versus a lump-sum benefit)

— Sends the Plan a Retirement/Surviving Spouse Form within 90 days after your death

Surviving children can continue coverage until they are ineligible under Plan rules – dependents may not be added after your death

- When your surviving spouse does not receive an annuity or when a lump-sum benefit is elected, your survivor(s) can continue coverage through COBRA

See provisions for Eligible Retirees for information on survivor coverage in the even of a retiree's death.

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Continuation of Coverage

If your coverage ends under the Plan, you may be entitled to elect continuation coverage (coverage that continues on in some form) in accordance with federal law.

Continuation coverage under COBRA (the federal Consolidated Omnibus Budget Reconciliation Act) is available only to Plans that are subject to the terms of COBRA. You can contact your Plan Administrator to determine if we are subject to the provisions of COBRA.

If you selected continuation coverage under a prior plan which was then replaced by coverage under this Plan, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed below, whichever is earlier.

Continuation Coverage under Federal Law (COBRA)

Much of the language in this section comes from the federal law that governs continuation coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who was covered under the Plan on the day before a qualifying event:

- A Participant.
- A Participant's Enrolled Dependent, including with respect to the Participant's children, a child born to or placed for adoption with the Participant during a period of continuation coverage under federal law.
- A Participant's former spouse.

To continue reading, go to right column on this page.

Qualifying Events for Continuation Coverage under Federal Law (COBRA)

If the coverage of a Qualified Beneficiary would ordinarily terminate due to one of the following qualifying events, then the Qualified Beneficiary is entitled to continue coverage. The Qualified Beneficiary is entitled to elect the same coverage that she or he had on the day before the qualifying event.

The qualifying events with respect to an employee who is a Qualified Beneficiary are:

A. Termination of the Participant from employment with us, for any reason other than gross misconduct, or reduction of hours; or
B. Death of the Participant; or
C. Divorce or legal separation of the Participant; or
D. Loss of eligibility by an Enrolled Dependent who is a child; or
E. Entitlement of the Participant to Medicare benefits; or
F. The Plan Sponsor filing for bankruptcy, under Title XI, United States Code, on or after July 1, 1986, but only for a retired Participant and his or her Enrolled Dependents. This is also a qualifying event for any retired Participant and his or her Enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

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Notification Requirements and Election Period for Continuation Coverage under Federal Law (COBRA)

The Participant or other Qualified Beneficiary must notify SHBP within 60 days of the Participant's divorce, legal separation or an Enrolled Dependent's loss of eligibility as an Enrolled Dependent. If the Participant or other Qualified Beneficiary fails to notify SHBP of these events within the 60 day period, SHBP is not obligated to provide continued coverage to the affected Qualified Beneficiary. If a Participant is continuing coverage under Federal Law, the Participant must notify SHBP within 60 days of the birth or adoption of a child.

Continuation must be elected by the later of 60 days after the qualifying event occurs; or 60 days after the Qualified Beneficiary receives notice of the continuation right from SHBP.

If the Qualified Beneficiary's coverage was terminated due to a qualifying event, then the initial premium due to SHBP must be paid on or before the 45th day after electing continuation.

Notification Requirements for Disability Determination or Change in Disability Status

The Participant or other Qualified Beneficiary must notify SHBP as described under "Terminating Events for Continuation Coverage under federal law (COBRA)", subsection A. below.

The notice requirements will be satisfied by providing written notice to SHBP at the address stated in Attachment II to this Summary Plan Description. The contents of the notice must be such that SHBP is able to determine the covered employee and Qualified Beneficiary or Qualified Beneficiaries, the qualifying event or disability, and the date on which the qualifying event occurred.

To continue reading, go to right column on this page.

None of the above notice requirements will be enforced if the Participant or other Qualified Beneficiary is not informed of his or her obligations to provide such notice.

After providing notice to SHBP, the Qualified Beneficiary shall receive the continuation coverage and election notice. Continuation coverage must be elected by the later of 60 days after the qualifying event occurs; or 60 days after the Qualified Beneficiary receives notice of the continuation right from SHBP.

The Qualified Beneficiary's initial premium due to SHBP must be paid on or before the 45th day after electing continuation.

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Participants who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These Participants are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If a Participant qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact SHBP for additional information. The Participant must contact SHBP promptly after qualifying for assistance under the Trade Act of 1974 or the

To continue reading, go to left column on next page.

Participant will lose his or her special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that Plan coverage was lost, but begins on the first day of the special second election period.

Terminating Events for Continuation Coverage under Federal Law (COBRA)

Continuation under the Plan will end on the earliest of the following dates:

A. Eighteen months from the date of the qualifying event, if the Qualified Beneficiary's coverage would have ended because the Participant's employment was terminated or hours were reduced (i.e., qualifying event A.).

   If a Qualified Beneficiary is determined to have been disabled under the Social Security Act at anytime within the first 60 days of continuation coverage for qualifying event A. then the Qualified Beneficiary may elect an additional 11 months of continuation coverage (for a total of 29 months of continued coverage) subject to the following condition: (i) notice of such disability must be provided within 60 days after the determination of the disability, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months; and (iii) if the Qualified Beneficiary entitled to the 11 months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

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B. Thirty-six months from the date of the qualifying event for an Enrolled Dependent whose coverage ended because of the death of the Participant, divorce or legal separation of the Participant, loss of eligibility by an Enrolled Dependent who is a child (i.e. qualifying events B., C., or D.).
C. For the Enrolled Dependents of a Participant who was entitled to Medicare prior to a qualifying event that was due to either the termination of employment or work hours being reduced, eighteen months from the date of the qualifying event, or, if later, 36 months from the date of the Participant's Medicare entitlement.
D. The date coverage terminates under the Plan for failure to make timely payment of the premium.
E. The date, after electing continuation coverage, that coverage is first obtained under any other group health plan. If such coverage contains a limitation or exclusion with respect to any preexisting condition, continuation shall end on the date such limitation or exclusion ends. The other group health coverage shall be primary for all health services except those health services that are subject to the pre-existing condition limitation or exclusion.
F. The date, after electing continuation coverage, that the Qualified Beneficiary first becomes entitled to Medicare, except that this shall not apply in the event that coverage was terminated because the Plan Sponsor filed for bankruptcy, (i.e. qualifying event F.).
G. The date the entire Plan ends.
H. The date coverage would otherwise terminate under the Plan as described in this section under the heading *Events Ending Your Coverage*.

If a Qualified Beneficiary is entitled to 18 months of continuation and a second qualifying event occurs during that time, the Qualified Beneficiary's coverage may be extended up to a maximum of 36

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months from the date coverage ended because employment was terminated or hours were reduced. If the Qualified Beneficiary was entitled to continuation because the Plan Sponsor filed for bankruptcy, (i.e. qualifying event F.) and the retired Participant dies during the continuation period, then the other Qualified Beneficiaries shall be entitled to continue coverage for 36 months from the date of the Participant's death. Terminating events B. through G. described in this section will apply during the extended continuation period.

Continuation coverage for Qualified Beneficiaries whose continuation coverage terminates because the Participant becomes entitled to Medicare may be extended for an additional period of time. Such Qualified Beneficiaries should contact SHBP for information regarding the continuation period.

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Section 10: General Legal Provisions

This section provides you with information about:
- General legal provisions concerning the Plan.

Plan Document

This Summary Plan Description presents an overview of your benefits. If there are discrepancies between the information in this SPD and DCH Board regulations or the laws of the state of Georgia, those regulations and laws will govern at all time.

Relationship with Providers

The relationships between us, United HealthCare and Contracted providers are solely contractual relationships between independent contractors. Contracted providers are not our agents or employees; nor are they agents or employees of United HealthCare. Neither we nor any of our employees are agents or employees of Contracted providers.

We do not provide health care services or supplies, nor do we practice medicine. Instead, we pay Benefits for Covered Health Services. Contracted providers are independent practitioners who run their own offices and facilities. The credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. Contracted providers are not our employees or employees of United

To continue reading, go to right column on this page.

HealthCare; nor do we have any other relationship with Contracted providers such as principal-agent or joint venture. Neither we nor United HealthCare are liable for any act or omission of any provider.

United HealthCare is not considered to be an employer of the SHBP for any purpose with respect to the administration or provision of benefits under this Plan.

SHBP is solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- Notifying you of the termination or modifications to the Plan.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider.
- You must decide if any provider treating you is right for you. This includes Contracted providers you choose and providers to whom you have been referred.
- You must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and us is that of Plan Sponsor and employee, Dependent or other classification as defined in the Plan.

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Incentives to You

Sometimes United HealthCare may offer incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but we recommend that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. Contact United HealthCare if you have any questions.

Rebates and Other Payments

SHBP and United HealthCare may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet your Annual Deductible. SHBP and United HealthCare do not pass these rebates on to you, nor are they applied to your Annual Deductible or taken into account in determining your Coinsurance.

Interpretation of Benefits

SHBP and United HealthCare have sole and exclusive discretion to do all of the following:

- Interpret Benefits under the Plan.
- Interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD and any Riders and Amendments.
- Make factual determinations related to the Plan and its Benefits.

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SHBP and United HealthCare may delegate this discretionary authority to other persons or entities who provide services in regard to the administration of the Plan.

Administrative Services

We may, in our sole discretion, arrange for various persons or entities to provide administrative services in regard to the Plan, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time in our sole discretion. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Clerical Error

If a clerical error or other mistake occurs, that error does not create a right to Benefits. These errors include, but are not limited to, providing misinformation on eligibility or Benefit coverages or entitlements. It is your responsibility to confirm the accuracy of statements made by us or our designees, including United HealthCare, in accordance with the terms of this SPD and other Plan documents.

Information and Records

At times we or United HealthCare may need additional information from you. You agree to furnish us and/or United HealthCare with all information and proofs that we may reasonably require regarding any matters pertaining to the Plan. If you do not provide this information when we request it, we may delay or deny payment of your Benefits.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish us

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or United HealthCare with all information or copies of records relating to the services provided to you. We or United HealthCare have the right to request this information at any reasonable time.

This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Participant's enrollment form. We and United HealthCare agree that such information and records will be considered confidential.

We and United HealthCare have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of the Plan, we, United HealthCare, and our related entities may use and transfer the information gathered under the Plan for research and analytic purposes.

For complete listings of your medical records or billing statements we recommend that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, we or United HealthCare will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Such designees have the same rights to this information as SHBP.

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Examination of Covered Persons

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Physician of our choice examine you at our expense.

Workers' Compensation not Affected

Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Medicare Eligibility

Benefits under the Plan are not intended to supplement any coverage provided by Medicare. Nevertheless, in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled under the Plan.

Subrogation and Reimbursement

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. If you receive a Benefit payment from the Plan for an Injury caused by a third party, and you later receive any payment for that same condition or Injury from another person, organization or insurance company, we have the right to recover any payments made by the Plan to you. This process of recovering earlier payments is called subrogation. In case of subrogation, you may be asked to sign and deliver information or documents necessary for us to protect our right to recover Benefit payments made. You agree to provide us all assistance necessary as a condition of participation in the Plan, including cooperation and information submitted to as supplied by a workers' compensation, liability insurance carrier, and any medical benefits, no-fault insurance, or school insurance coverage that are

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paid or payable.

We shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type, for the reasonable value of services and Benefits we provided to you from any or all of the following:

- Third parties, including any person alleged to have caused you to suffer injuries or damages.
- Your employer.
- Any person or entity obligated to provide benefits or payments to you.

You agree as follows:

- To cooperate with us in protecting our legal rights to subrogation and reimbursement.
- That you will do nothing to prejudice our rights under this provision, either before or after the need for services or benefits under the Plan.
- That we may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions.
- To execute and deliver such documents, including consent to release medical records, and provide such help (including responding to requests for information about any accident or injuries and making court appearances) as we may reasonably request from you.

Refund of Overpayments

If we pay Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization

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that was paid, must make a refund to us if either of the following apply:

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment we made exceeded the Benefits under the Plan.

The refund equals the amount we paid in excess of the amount we should have paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help us get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits that are payable under the Plan. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

Limitation of Action

If you want to bring a legal action against us or United HealthCare you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against us or United HealthCare.

You cannot bring any legal action against us or United HealthCare for any other reason unless you first complete all the steps in the appeal process described in this document. After completing that process, if you want to bring a legal action against us or United HealthCare you must do so within three years of the date you are notified of our final decision on your appeal, or you lose any rights to bring such an action against us or United HealthCare.

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Rights and Responsibilities

Your Rights as an Employee Enrolled in Plan Coverage

As an employee enrolled in Plan coverage, you have the right to:

- Have your eligible claims paid and notifications provided in a timely manner
- Receive information about the Plan and the options available to you
- Be informed of the process for filing appeals of denied claims
- Have access to Provider information
- Review your appeal file
- Examine, without charge, all documents governing the Plan at the Plan Administrator's office
- Request copies of the above documents, in writing, from the Plan Administrator (a reasonable copy fee may apply)
- Be informed by the Plan of how to continue your coverage if it would otherwise end in certain situations

Your Rights for Continuing Group Health Plan Coverage

- You have the right to continue group health plan coverage if you lose Plan coverage due to a qualifying event. In this case, you may continue health care coverage for yourself, spouse or dependents; however, you or your dependents may have to pay for such coverage. Review this Summary Plan Description (SPD) and other Plan documents governing your COBRA continuation coverage rights.

Your Responsibilities as an Employee Enrolled in Plan Coverage

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As an employee enrolled in Plan coverage, you can receive the most value from your coverage if you fulfill the following responsibilities:

Make proper and timely premium payments. Premium payments usually are made through convenient payroll deduction. It's your responsibility to make sure that your employer (the State, school district, agency, etc.) is deducting the right amount from your paycheck for your option and coverage type. When you are first hired, and later during each Open Enrollment (or Retiree Option Change Period), you will receive premium information. If you are mailing premiums to the Plan – when you are on leave without pay, for example – your payments must be received on time at the Plan.

Make accurate enrollment choices. When you fill out Plan forms, for example, make sure that you check the box or line that corresponds to your desired selection. After the Open Enrollment period ends, the Plan will make changes only when there is a documented administrative error. Any premium refund will be limited to 12 months of premiums and is payable only after the Plan receives documented evidence from the Participant that the Plan had no liability for additional covered persons.

Take the time to understand how the Plan option works. You are the manager of your health care needs and, therefore, you must take the time to understand your Plan option in order to make the best decisions. You also are responsible for understanding the consequences of your decisions. Carefully review this booklet and the *Health Plan Decision Guides*. Having read the documents, you can take steps to maximize your coverage once enrolled in the Plan.

Know when and how your participation can end. Generally, coverage ends when you no longer meet job classification or working-hours requirements for eligibility or when you fail to make the proper premium payments. For eligibility requirements and other circumstances that may result in loss of coverage, see Sections 4 & 5.

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Follow Prior Approval procedures. This process assesses certain procedures, services and equipment to determine if they are covered under the Plan based on medical policy and guidelines. You or your Physician can contact Care Coordination to initiate the Prior Approval process.

Notify the SHBP of an address change. Advise the Plan by telephone or in writing if you or your Covered Dependents move so that you receive benefit checks and receive important notices about Plan changes. Call or visit your personnel/payroll office or notify the Plan directly at SHBP, Department of Community Health, P.O. Box 38342, Atlanta, GA 30334. Include your Social Security Number in your notification.

Notify the Plan if you have a qualifying event that can affect coverage or eligibility for coverage for you or a Covered Dependent. If you get married, divorced or have a baby, you may want to add or delete a dependent. You must notify the Plan by sending written documentation of the event within 31 days of the event – or you won't be able to make the change until the next Open Enrollment period. Retirees do not have an Open Enrollment period; failure to notify the Plan within 31 days of a qualified change in status could permanently prohibit a retiree from making the desired change.

Furnish the Plan with information required to implement Plan provisions. You are required to provide any information and documentation that the Plan needs to carry out its provisions. If you do not provide the information, your request for benefits or Plan membership will be denied. If the Plan pays benefits for a dependent who is subsequently found ineligible for coverage, or you are not able to document dependent eligibility when requested by the Plan, the Plan has the right to:

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— Recover any and all payments made by the Plan on behalf of the ineligible dependent, and

— Terminate the dependent's coverage retroactively to his or her coverage effective date without prejudicing any other rights or remedies available to the Plan under law.

Update the Plan on the status of eligible dependents. If your dependent child is nearing age 19, you are responsible for informing the Plan of his or her status. Coverage won't continue automatically after an eligible dependent turns 19 – you must request it. You also must notify the Plan when a dependent gets married, enters the military or, when the dependent is 19 or older, graduates or stops attending school full time.

Notify the Plan of any other group coverage you have, including Medicare coverage. You may be required to provide notification in advance or on request.

Your Employer's Responsibilities

Your employer – your department, agency or other entity – has specific responsibilities under the Plan, which include the following:

- Submit Membership Forms and all other necessary documentation in a timely and efficient manner.
- Withhold proper monthly premiums and submit them, along with a reconciled invoice, to the Plan within 10 days after they are due. If your employer does not send in premiums, documentation and reconciliation in a proper and timely manner, the Plan may suspend benefit payments.
- Enroll all eligible full-time employees in the Plan, unless the employee declines coverage. Your employer must give you either

To continue reading, go to left column on next page.

a Membership Form or a Declination Form during your first 15 days on the job.

- Provide enrollment information to the SHBP.
- Distribute Plan materials, including this SPD booklet, and hold group meetings to give you information about the Plan at the Plan Administrator's request.
- Administer the Family and Medical Leave Act (FMLA) in compliance with federal law.
- Provide you with information on how you can continue coverage under the FMLA and under state leave-without-pay provisions.
- Provide necessary termination of coverage information to the Plan Administrator within 30 days after your employment ends or your eligibility for Plan Membership ends.
- Notify enrolled employees of Plan amendments or termination.

Assistance With Your Questions

If you have any questions about your rights and responsibilities under this Plan, you should contact the Plan's Eligibility Unit at 404-656-6322 in Atlanta, or at 800-610-1863 outside of Atlanta.

Department of Community Health Privacy Notice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

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The Plan's Privacy Commitment to You

The Georgia Department of Community Health (DCH) understands that information about you and your family is personal. DCH is committed to protecting your information. This notice tells you how DCH uses and discloses information about you. It tells you your rights and the Plan's requirements about your information.

Understanding the Type of Information That the Plan Has

Your employer (state agency, school system, authority, etc.) sent information about you to DCH. This information included your name, address, birth date, phone number, Social Security Number and other health insurance policies that you may have. It may also have included health information. When your health care Providers send claims to United Healthcare for payment, the claims include your diagnoses and the medical treatments you received. For some medical treatments, your health care Providers send additional medical information to the Plan such as doctor's statements, x-rays or lab test results.

Your Health Information Rights

You have the following rights regarding the health information that DCH has about you.

- You have the right to see and obtain a copy of your health information. An exception is psychotherapy notes. Another exception is information that is needed for a legal action relating to DCH.
- You have the right to ask DCH to change health information that is incorrect or incomplete. DCH may deny your request under certain circumstances.

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- You have the right to request a list of the disclosures that DCH has made of your health information beginning in April 2003.
- You have the right to request a restriction on certain uses or disclosures of your health information. DCH is not required to agree with your request.
- You have the right to request that DCH communicates with you about your health in a way or at a location that will help you keep your information confidential.
- You have the right to receive a paper copy of this notice. You may ask DCH staff to give you another copy of this notice, or you may obtain a copy from DCH's Web site, www.dch.georgia.gov (click on "Privacy").

Privacy Law's Requirements

DCH is required by law to:

- Maintain the privacy of your information.
- Give you this notice of DCH's legal duties and privacy practices regarding the information that DCH has about you.
- Follow the terms of this notice.
- Not use or disclose any information about you without your written permission, except for the reasons given in this notice. You may take away your permission at any time, in writing, except for the information that DCH disclosed before you stopped your permission. If you cannot give your permission due to an emergency, DCH may release the information if it is in your best interest. DCH must notify you as soon as possible after releasing the information.

In the future, DCH may change its privacy practices. If its privacy practices change significantly, DCH will provide a new notice to you. DCH will post the new notice on its Web site at www.dch.georgia.gov (click on "Privacy"). This notice is effective April 14, 2003.

To continue reading, go to right column on this page.

How DCH Uses and Discloses Health Care Information

There are some services the Plan provides through contracts with private companies. For example, United Healthcare pays most medical claims to your health care providers. When services are contracted, the Plan may disclose some or all of your information to the company so that they can perform the job the Plan has asked them to do. To protect your information, the Plan requires the company to safeguard your information in accordance with the law.

The following categories describe different ways that the Plan uses and discloses your health information. For each category, we will explain what we mean and give an example.

For Payment: The Plan may use and disclose information about you so that it can authorize payment for the health services that you received. For example, when you receive a service covered by the Plan, your health care provider sends a claim for payment to United Healthcare.

The claim includes information that identifies you, as well as your diagnoses and treatments.

For Medical Treatment: The Plan may use or disclose information about you to ensure that you receive necessary medical treatment and services. For example, if you participate in a Disease State Management Program, the Plan may send you information about your condition.

To Operate Various Plan Programs: The Plan may use or disclose information about you to run various Plan programs and ensure that

To continue reading, go to left column on next page.

you receive quality care. For example, the Plan may contract with a company that reviews Hospital records to check on the quality of care that you received and the outcome of your care.

To Other Government Agencies Providing Benefits or Services: The Plan may give information about you to other government agencies that are giving you benefits or services. The information must be necessary for you to receive those benefits or services.

To Keep You Informed: The Plan may mail you information about your health and well-being. Examples are information about managing a disease that you have, information about your managed care choices, and information about Prescription Drugs you are taking.

For Overseeing Health Care Providers: The Plan may disclose information about you to the government agencies that license and inspect medical facilities, such as Hospitals, as required by law.

For Research: The Plan may disclose information about you for a research project that has been approved by a review board. The review board must review the research project and its rules to ensure the privacy of your information. The research must be for the purpose of helping the Plan.

As Required by Law: The Plan will disclose information about you as required by law.

For More Information and to Report a Problem

If you have questions and would like additional information, you may contact the SHBP at 404-656-6322 (Atlanta calling area) or 800-610-1863 (outside of Atlanta calling area). If you believe your privacy rights have been violated:

- You can file a complaint with the Plan by calling the SHBP at 404-656-6322 (Atlanta calling area) or 800-610-1863 (outside of Atlanta calling area), or by writing to: SHBP – HPU, P.O. Box 38342, Atlanta, GA 30334.
- You can file a complaint with the Health and Human Services Office for Civil Rights, Region IV, Atlanta Federal Center, 61 Forsyth Street SW, Suite 3B70, Atlanta, GA 30303-8909. Phone 404-562-7886; Fax 404-562-7884.
- You may also contact the HHS Office for Civil Rights by calling 1-866-OCR-PRIV 1-866-627-7748 or e-mail to OCR at OCRComplaint@hhs.gov.

There will be no retaliation for filing a complaint or grievance.

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Section 11: Glossary of Defined Terms

This section:
- Defines the terms used throughout this SPD.
- Is not intended to describe Benefits.

Alternate Facility - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health Services or Substance Abuse Services on an outpatient or inpatient basis.

Amendment - any attached written description of additional or alternative provisions to the Plan. Amendments are effective only when signed by the SHBP and United HealthCare. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that are specifically amended.

To continue reading, go to right column on this page.

Annual Deductible - the amount you must pay for Covered Health Services in a calendar year before the SHBP will begin paying for Benefits in that calendar year.

The actual amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. See the definition of Eligible Expenses below.

Benefits - your right to payment for Covered Health Services that are available under the Plan. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of the Plan, including this SPD and any attached Riders and Amendments.

Clinical Cancer Trial Services - clinical trials study the effectiveness of new interventions. There are different types of cancer clinical trials such as:

- prevention trials;
- early detection trials;
- treatment trials to test new therapies in individuals who have cancer;
- quality of life studies;
- studies to evaluate ways of modifying cancer-causing behaviors.

Clinical trials follow strict scientific guidelines that deal with many areas such as:

- study design,
- who can be in the study,
- the kind of information individuals in the study must be given when they decide to participate.

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Clinical trials follow protocols for determining:

- the number of participants;
- what drugs participants will take;
- what medical tests they will have; and
- how often and what information will be collected.

There are four phases of clinical trials. Clinical trials pilot program will include all phases of clinical trials, as long as they meet the criteria defined for the program.

Phase I Trials evaluate how a new drug should be administered and enroll only a small number of patients.
Phase II Trials provide preliminary information about how well a new drug works and generates more information about safety and benefits of the new drug or procedure.
Phase III Trials compare a promising new drug, a combination of drugs or a procedure with the current standard. This phase involves large numbers of people in doctors' offices, clinics and cancer centers. (Many of our members will be in this category). This phase utilizes a randomized process of assigning participants to the standard intervention or the trial intervention.
Phase IV Trials continue the evaluation of drugs after FDA approval and utilize drugs already on the market and available for general use.

Congenital Anomaly - a physical developmental defect that is present at birth, and is identified within the first twelve months of birth.

Coinsurance - .is a percentage of Eligible Expenses determined after the deductible has been satisfied.

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Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by United HealthCare on behalf of the SHBP.

Covered Health Service(s) -those health services provided for the purpose of preventing, diagnosing or treating a Sickness, Injury, Mental Illness, substance abuse, or their symptoms.

A Covered Health Service is a health care service or supply described in (Section 1: What's Covered--Benefits) as a Covered Health Service, which is not excluded under (Section 2: What's Not Covered--Exclusions).

Covered Person - either the Participant or an Enrolled Dependent, but this term applies only while the person is enrolled under the Plan. References to "you" and "your" throughout this SPD are references to a Covered Person.

Custodial Care - services that:

- Are non-health related services, such as assistance in activities of daily living (including but not limited to feeding, dressing, bathing, transferring and ambulating); or
- Are health-related services which do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing; or
- Do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

To continue reading, go to left column on next page.

Dependent - your eligible dependent that participates in the Plan, which can include am eligible spouse, child, full-time student or totally disabled child.

Designated Facility - a facility that has entered into an agreement on behalf of the facility and its affiliated staff with United HealthCare or with an organization contracting on its behalf to render Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated Facility.

Durable Medical Equipment - medical equipment that is all of the following:

- Can withstand repeated use.
- Is not disposable, except urinary catheters and ostomy supplies.
- Is manufactured and used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Is appropriate for use in the home.

Eligible Expenses - for Covered Health Services incurred while the Plan is in effect, Eligible Expenses are determined as stated below: For Network Benefits, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from Contracted providers, Eligible Expenses are the contracted fee(s) with that provider.
- When Covered Health Services are received from non-Contracted providers as a result of an Emergency or as otherwise arranged through United HealthCare, Eligible Expenses are paid at reasonable and customary charges unless a lower amount is negotiated.

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For Non-Network Benefits, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from non-Contracted providers, Eligible Expenses are determined, at United HealthCare's discretion, based on:

— Available data resources of competitive fees in that geographic area.

— Fee(s) that are negotiated with the provider.

— A fee schedule that United HealthCare develops.

Eligible Expenses are determined solely in accordance with United HealthCare's reimbursement policy guidelines. The reimbursement policy guidelines are developed, at United HealthCare's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that United HealthCare accepts.

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Eligible Person The Participant who may be the employee, teacher, retiree, contract employee or extended beneficiary, who is eligible for Plan coverage and who has paid the necessary deduction or premium for such coverage.

Emergency - a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness which is both of the following:

- Arises suddenly.
- In the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

Emergency Health Services - health care services and supplies necessary for the treatment of an Emergency.

Experimental or Investigational Services - medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time determination is made regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use.
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

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If you have a life-threatening Sickness or condition (one which is likely to cause death within one year of the request for treatment) we may, in our discretion, determine that an Experimental or Investigational Service meets the definition of a Covered Health Service for that Sickness or condition. For this to take place, we must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Full-time Student - a person who is enrolled in and attending, full-time, a recognized course of study or training at one of the following:

- An accredited high school.
- An accredited college or university.
- A licensed vocational school, technical school, occupational, specialized or similar training school.

Full-time Student status is determined in accordance with the standards set forth by the educational institution. You are no longer a Full-time Student at the end of the calendar month you graduate or otherwise cease to be enrolled and in attendance at the institution on a full-time basis.

You continue to be a Full-time Student during periods of regular vacation established by the institution. If you do not continue as a Full-time Student immediately following the period of vacation, the Full-time Student designation will end as described above.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

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Hospital - an institution, operated as required by law, that is both of the following:

- Is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- Has 24 hour nursing services.

A Hospital is not primarily a place for rest, custodial care or care of the aged and is not a nursing home, convalescent home or similar institution.

Initial Enrollment Period - the initial period of time, as determined by SHBP, during which Eligible Persons may enroll themselves and their Dependents under the Plan.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Maximum Plan Benefit - the maximum amount that we will pay for Benefits during the entire period of time that you are enrolled under the Plan, or any other plan of SHBP. When the Maximum Plan Benefit applies, it is described in (Section 1: What's Covered--Benefits).

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Medicare - Parts A, B and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services - Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance Abuse Designee - the organization or individual, designated by United HealthCare, that provides or arranges Mental Health Services and Substance Abuse Services for which Benefits are available under the Plan.

Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded under the Plan.

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with United HealthCare or with United HealthCare's affiliate to participate in United HealthCare's Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Shared Savings Program. United HealthCare's affiliates are those entities affiliated with them through common ownership or control with United HealthCare or with its ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Contracted provider for only some of United HealthCare's products. In this case, the provider will be a Contracted provider for the Covered Health Services and products included in the

To continue reading, go to left column on next page.

participation agreement, and a non-Contracted provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - Benefits for Covered Health Services that are provided by a Network Physician or other Contracted provider. Network Benefits include Emergency Health Services.

Non-Network Benefits - Benefits for Covered Health Services that are provided by a non-Network Physician or other non-Contracted provider.

Open Enrollment Period - a period of time that follows the Initial Enrollment Period during which Eligible Persons may enroll themselves and Dependents under the Plan, as determined by the SHBP.

Out-of-Pocket Maximum - the maximum amount of Annual Deductible and Coinsurance you pay every calendar year. If you use both Network Benefits and Non-Network Benefits, two separate Out-of-Pocket Maximums apply. Once you reach the Out-of-Pocket Maximum for Network Benefits, Benefits for those Covered Health Services that apply to the Out-of-Pocket Maximum are payable at 100% of Eligible Expenses during the rest of that calendar year. Once you reach Out-of-Pocket Maximum for Non-Network Benefits, Benefits for those Covered Health Services that apply to the Out-of-Pocket Maximum are payable at 100% of Eligible Expenses during the rest of that calendar year.

Coinsurance for some Covered Health Services will never apply to the Out-of-Pocket Maximum, as specified in (Section 1: What's Covered--Benefits) and those Benefits will never be payable at 100% even when the Out-of-Pocket Maximum is reached.

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The following costs will never apply to the Out-of-Pocket Maximum:

- Any charges for non-Covered Health Services;
- The amount of any reduced Benefits if you don't notify United HealthCare as described in (Section 1: What's Covered--Benefits) under the *Notify United HealthCare?* column.
- Charges that exceed Eligible Expenses.

Participant - an Eligible Person who is properly enrolled under the Plan. The Participant is the person (who is not a Dependent) on whose behalf the Plan is established.

Physician - any Doctor of Medicine, "M.D.", or Doctor of Osteopathy, "D.O.", who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan - High Deductible PPO Plan for the State Health Benefit Plan.

Plan Administrator –United HealthCare Insurance Company.

Pre-existing Condition - an Injury or Sickness that is identified by SHBP as having been diagnosed or treated, or for which prescription medications or drugs were prescribed or taken within the six month period ending on the person's enrollment date. (The enrollment date is the date the person became covered under the Plan or, if earlier, the first day of any waiting period under the Plan.) A Preexisting Condition does not include Pregnancy. Genetic information is not an indicator of a Preexisting Condition, if there is not a diagnosis of a condition related to the genetic information.

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Qualified Medical Child Support Order (QMCSO) **–** Any judgment, decree order (including approval of a settlement agreement), or National Medical Support Notice that a court of competent jurisdiction or a state agency issues. The order must provide for medical coverage for your natural child.

Rider - any attached written description of additional Covered Health Services not described in this SPD. Riders are effective only when signed by SHBP and are subject to all conditions, limitations and exclusions of the Plan except for those that are specifically amended in the Rider.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Shared Savings Program - the Shared Savings Program provides access to discounts from the provider's charges when services are rendered by those non-Contracted providers that participate in that program. United HealthCare will use the Shared Savings Program to pay claims when doing so will lower Eligible Expenses. United HealthCare does not credential the Shared Savings Program providers and the Shared Savings Program providers are not Contracted providers. Accordingly, Benefits for Covered Health Services provided by Shared Savings Program providers will be paid at the Non-Network Benefit level (except in situations when Benefits for Covered Health Services provided by non-Contracted providers are payable at Network Benefit levels, as in the case of Emergency Health Services). When United HealthCare uses the Shared Savings Program to pay a claim, patient responsibility is limited to Coinsurances calculated on the contracted rate paid to the provider, in addition to any required Annual Deductible.

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SHBP –State Health Benefit Plan. References to "we", "us", and "our" throughout the SPD refer to SHBP.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this SPD does not include Mental Illness or substance abuse, regardless of the cause or origin of the Mental Illness or substance abuse.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

Spinal Treatment - detection or correction (by manual or mechanical means) of subluxation(s) in the body to remove nerve interference or its effects. The interference must be the result of, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Substance Abuse Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance abuse disorders that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded. The fact that a disorder is listed in the Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment of the disorder is a Covered Health Service.

Transition of Care**-** Transition of care is a service that enables new enrollees to receive time-limited care for specified medical conditions from a non-contracted physician at the benefit level associated with contracted physicians.

Unproven Services - services that are not consistent with conclusions of prevailing medical research which demonstrate that the health service has a beneficial effect on health outcomes and that are not based on trials that meet either of the following designs.

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- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we and United HealthCare may, in our discretion, determine that an Unproven Service meets the definition of a Covered Health Service for that Sickness or condition. For this to take place, we and United HealthCare must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Urgent Care Center - a facility, other than a Hospital, that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

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Riders, Amendments, Notices

Outpatient Prescription Drug Rider

Attachment I

High Deductible PPO Plan

Outpatient Prescription Drug Rider

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Outpatient Prescription Drug Rider

This Rider to the Summary Plan Description provides Benefits for outpatient Prescription Drug Products.

Benefits are provided for outpatient Prescription Drug Products at a Network Pharmacy.

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in (Section 11: Glossary of Defined Terms) of the Summary Plan Description and in (Section 3: Glossary of Defined Terms) of this Rider.

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When we use the words "we," "us," and "our" in this document, we are referring to Plan Sponsor. When we use the words "you" and "your" we are referring to people who are Covered Persons as the term is defined in the Summary Plan Description (Section 11: Glossary of Defined Terms).

NOTE: The Coordination of Benefits provision (Section 8: Coordination of Benefits) in the Summary Plan Description does not apply to Prescription Drug Products covered through this Rider. Prescription Drug Product Benefits will not be coordinated with those of any other health coverage plan.

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Introduction

Benefits for Outpatient Prescription Drug Products

Benefits are available for Outpatient Prescription Drug Products on the Prescription Drug List at a Network Pharmacy and are subject to Coinsurance or other payments that vary depending on which of the three tiers of the Prescription Drug List the Outpatient Prescription Drug is listed.

Coverage Policies and Guidelines

United HealthCare's Prescription Drug List ("PDL") Management Committee is authorized to make tier placement changes on our behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether supply limits or notification requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, available rebates, and assessments on the cost effectiveness of the Prescription Drug Product.

United HealthCare may periodically change the placement of a Prescription Drug Product among the tiers. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to you.

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When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

NOTE: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please access www.myuhc.com through the Internet, or call the Customer Service number on your ID card for the most up-to-date tier status.

Identification Card (ID Card) - Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified during regular business hours.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug Product at the pharmacy.

You may seek reimbursement from us as described in Summary Plan Description (Section 6: How to File a Claim). When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Cost, less the required Coinsurance, Ancillary Charge, and any deductible that applies.

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Designated Pharmacies

If you require certain Prescription Drug Products, United HealthCare may direct you to a Designated Pharmacy with whom they have an exclusive arrangement to provide those Prescription Drug Products.

In this case, Benefits will only be paid if your Prescription Order or Refill is obtained from the Designated Pharmacy.

Limitation on Selection of Pharmacies

If we determine that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, we may require you to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 31 days of the date we notify you, we will select a single Network Pharmacy for you.

Rebates and Other Payments

United HealthCare, and a number of its affiliated entities, conduct business with various pharmaceutical manufacturers separate and apart from this Outpatient Prescription Drug Rider. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this Outpatient Prescription Drug Rider. United HealthCare is not required to pass on to you, and does not pass on to you, such amounts.

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Coupons, Incentives and Other Communications

At various times, we or United HealthCare may send mailings to you or to your Physician that communicate a variety of messages, including information about Prescription Drug Products. These mailings may contain coupons or offers from pharmaceutical manufacturers that enable you, at your discretion, to purchase the described drug product at a discount or to obtain it at no charge. Pharmaceutical manufacturers may pay for and/or provide the content for these mailings. Only your Physician can determine whether a change in your Prescription Order or Refill is appropriate for your medical condition.

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Section 1: What's Covered--Prescription Drug Benefits

We provide Benefits under the Plan for outpatient Prescription Drug Products:

- Designated as covered at the time the Prescription Order or Refill is dispensed when obtained from a Network Pharmacy.
- Refer to exclusions in your Summary Plan Description (Section 2: What's Not Covered--Exclusions) and as listed in Section 2 of this Rider.

Benefits for Outpatient Prescription Drug Products

Benefits for outpatient Prescription Drug Products are available when the outpatient Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

To continue reading, go to right column on this page.

When a Brand-name Drug Becomes Available as a Generic

When a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Coinsurance may change and an Ancillary Charge may apply. You will pay the Coinsurance applicable for the tier to which the Prescription Drug Product is assigned.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description of Pharmacy Type and Supply Limits" column of the Benefit Information table. You may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that United HealthCare has developed, subject to its periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply.

You may determine whether a Prescription Drug Product has been assigned a maximum quantity level for dispensing through the Internet at www.myuhc.com or by calling Customer Service at the telephone number on your ID card.

Notification Requirements

Before certain Prescription Drug Products are dispensed to either you, your Physician, your pharmacist is required to notify United HealthCare. The reason for notification is to determine whether the Prescription Drug Product, in accordance with our approved guidelines, is each of the following:

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- It meets the definition of a Covered Health Service.
- It is not Experimental, Investigational or Unproven.

Network Pharmacy Notification

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for notifying United HealthCare.

If United HealthCare is not notified before the Prescription Drug Product is dispensed, you may pay more for that Prescription Order or Refill. The Prescription Drug Products requiring notification are subject to periodic review and modification. You may determine whether a particular Prescription Drug Product requires notification through the Internet at www.myuhc.com or by calling the Customer Service number on your ID card.

If United HealthCare is not notified before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Summary Plan Description (Section 6: How to File a Claim).

When you submit a claim on this basis, you may pay more because you did not notify United HealthCare before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Cost, less the required Coinsurance, Ancillary Charge, and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after the documentation provided is reviewed and it is determined that the Prescription Drug Product is not a Covered Health Service or it is Experimental, Investigational or Unproven.

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What You Must Pay

You are responsible for paying the applicable Coinsurance amount described in the Benefit Information table, in addition to any Ancillary Charge when Prescription Drug Products are obtained from a retail pharmacy.

The Ancillary Charge applies when a covered Prescription Drug Product is dispensed at your request, when a chemically equivalent Prescription Drug Product is available on a lower tier.

The amount you pay for any of the following under this Rider will be included in calculating **any Out-of-Pocket Maximum stated in your Summary Plan Description**:

- Coinsurance for Prescription Drug Products
- Ancillary Charges.
- Deductibles

You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Cost) will not be available to you and will not apply to out of pocket maximum.

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Payment Information

Payment Term	Description	Amounts

Coinsurance

Coinsurance for a Prescription Drug Product at a Network Pharmacy can be either a specific dollar amount or a percentage of the Prescription Drug Cost.

Your Coinsurance is determined by the tier to which United HealthCare's Prescription Drug List Management Committee has assigned a Prescription Drug Product.

NOTE: The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on United HealthCare's Prescription Drug List Management Committee's periodic tiering decisions. When that occurs, your Coinsurance may change. Please access www.myuhc.com through the Internet, or call the Customer Service number on your ID card for the most up-to-date tier status.

For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of:

- The applicable Coinsurance or
- The Network Pharmacy's Usual and Customary Charge (which includes a dispensing fee and sales tax) for the Prescription Drug Product.

See the Coinsurance stated in the Benefit Information table for amounts.

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Description of Pharmacy Type and Supply Limits	Your Coinsurance Amount
Prescription Drugs from a Retail Network Pharmacy Benefits are provided for outpatient Prescription Drug Products dispensed by a retail Network Pharmacy. The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • As written by the provider, coinsurance or two times minimum/maximum amount for 90-day supply of a Maintenance Drug Product, determined by DCH and United HealthCare. • A one-cycle supply of an oral contraceptive. You may obtain up to three cycles at one time if you pay a Coinsurance percentage for each cycle supplied.	**Your Coinsurance is determined by the tier to which United HealthCare's Prescription Drug List Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2 or Tier-3. Please access www.myuhc.com through the Internet, or call the Customer Service number on your ID card to determine tier status.** **Coverage up to 31-day supply:** 20% after satisfying the $1,100 deductible (Prescription Drug and Medical Deductible combined) $10 minimum / $100 maximum per prescription
Prescription Drugs from a Retail Network Pharmacy	**Coverage up to 90-day supply:** 20% after satisfying the $1,100 deductible (Prescription Drug and Medical Deductible combined) $20 minimum / $200 maximum per prescription

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Section 2: What's Not Covered--Exclusions

Exclusions from coverage listed in the Summary Plan Description apply also to this Rider. In addition, the following exclusions apply:

1. Outpatient Prescription Drug Products obtained from a non-Network Pharmacy.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
3. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
4. Drugs which are prescribed, dispensed or intended for use while you are an inpatient in a Hospital, Skilled Nursing Facility, or Alternate Facility.
5. Experimental, Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by United HealthCare to be experimental, investigational or unproven.
6. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.

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7. Prescription Drug Products for any condition, Injury, Sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
8. Any product dispensed for the purpose of appetite suppression and other weight loss products.
9. A specialty medication Prescription Drug Product (including, but not limited to, immunizations and allergy serum) which, due to its characteristics as determined by United HealthCare, must typically be administered or supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
10. Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
11. General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
12. Unit dose packaging of Prescription Drug Products.
13. Medications used for cosmetic purposes.
14. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that are determined to not be a Covered Health Service.
15. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
16. Prescription Drug Products when prescribed to treat infertility.
17. Prescription Drug Products for smoking cessation.

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18. Compounded drugs that do not contain at least one ingredient that requires a Prescription Order or Refill. Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier-3.
19. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed. Any Prescription Drug Product that is therapeutically equivalent to an over-the-counter drug. Prescription Drug Products that are comprised of components that are available in over-the-counter form or equivalent.
20. New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by United HealthCare's Prescription Drug List Management Committee.
21. Growth-hormone therapy, with the exception of diagnostic testing to rule out a diagnosis. Once diagnosed growth-hormone therapy is not covered.

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Section 3: Glossary of Defined Terms

This section:

- Defines the terms used throughout this Rider. Other defined terms used throughout this Rider can be found in (Section 11: Glossary of Defined Terms) of your Summary Plan Description.
- Is not intended to describe Benefits.

Ancillary Charge - a charge, in addition to the Coinsurance, that you are required to pay when a covered Prescription Drug Product is dispensed at your request, when a chemically equivalent Prescription Drug Product is available on a lower tier. For Prescription Drug Products from Network Pharmacies, the Ancillary Charge is calculated as the difference between the Prescription Drug Cost or MAC list price for Network Pharmacies for the Prescription Drug Product on the higher tier, and the Prescription Drug Cost or MAC list price of the chemically equivalent Prescription Drug Product available on the lower tier.

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Brand-name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that United HealthCare identifies as a Brand-name product, based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by United HealthCare.

Designated Pharmacy - a pharmacy that has entered into an agreement on behalf of the pharmacy with United HealthCare or with an organization contracting on its behalf, to provide specific Prescription Drug Products. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Generic - a Prescription Drug Product: (1) that is chemically equivalent to a Brand-name drug; or (2) that United HealthCare identifies as a Generic product based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by United HealthCare.

Maximum Allowable Cost (MAC) List - a list of Generic Prescription Drug Products that will be covered at a price level that United HealthCare establishes. This list is subject to periodic review and modification.

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with United HealthCare or its designee to provide Prescription Drug Products to Covered Persons.

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- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by United HealthCare as a Network Pharmacy.

A Network Pharmacy can be either a retail or a home delivery pharmacy.

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the FDA, and ending on the earlier of the following dates:

- The date it is assigned to a tier by United HealthCare's Prescription Drug List Management Committee.
- December 31st of the following calendar year.

Prescription Drug Cost - the rate we have agreed to pay our Network Pharmacies, including a dispensing fee and any sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

Prescription Drug List - a list that identifies those Prescription Drug Products for which Benefits are available under this Rider. This list is subject to periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug Product has been assigned through the Internet at www.myuhc.com or by calling the Customer Service number on your ID card.

Prescription Drug List Management Committee – the committee that United HealthCare designates for, among other responsibilities, classifying Prescription Drug Products into specific tiers.

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Prescription Drug Product - a medication, product or device that has been approved by the Food and Drug Administration and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Plan, this definition includes:

- Inhalers (with spacers).
- Insulin.
- The following diabetic supplies:

— standard insulin syringes with needles;

— blood-testing strips - glucose;

— urine-testing strips - glucose;

— ketone-testing strips and tablets;

— lancets and lancet devices;

— glucose monitors.

Prescription Order or Refill - the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties.

- End of Outpatient Prescription Drug Rider -

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Attachment I

Women's Health and Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act of 1998, we provide Benefits under the Plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Coinsurance and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).